Supreme Court, U.S.
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CASE NO.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1991

DR. SIDNEY S. LOXLEY, PETITIONER

v.

NEWPORT NEWS SHIPBUILDING AND
DRY DOCK COMPANY

AND

OFFICE OF WORKERS' COMPENSATION PROGRAMS,
UNITED STATES DEPARTMENT OF LABOR

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
FOURTH COURT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, without Congressional authority, an employer can use the allowable payments for medical care under its health benefit plan as a mandatory fee schedule to set the medical charges that prevail in the community under the Longshoremen and Harbor Workers' Compensation Act.

2. Whether the health care provider or the party objecting to his fees bears the burden of proof in the adjudication of a dispute as to the prevailing rate limitation on medical fees under the Longshoremen and Harbor Workers' Compensation Act.

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PROCEEDINGS IN THIS CASE

Reference to the reports of opinions delivered by other courts and administrative agencies, in reverse chronological order, are as follows:

1. Newport News Shipbuilding and Dry Dock Company v. Dr. Sidney S. Loxley, Dr. Lawrence D. Bourgard, and Director, Office of Workers' Compensation Programs, United States Department of Labor, 934 F.2d 511 (4th Cir. 1991), reh. denied, July 17, 1991.

2. Dr. Sidney S. Loxley and Dr. Lawrence D. Bourgard v. Newport News Shipbuilding and Dry Dock Company, BRB No. 87-1666 (BRB February 28, 1990).

3. Dr. Sidney S. Loxley and Dr. Lawrence D. Bourgard v. Newport News Shipbuilding and Dry Dock Company, 86-LHC-1235, et al. (OALJ May 27, 1987).

JURISDICTION

This petition is for a writ of certiorari pursuant to 28 U.S.C. § 1254(1) of a decision of the United States Court of Appeals for the Fourth Circuit decided on May 21, 1991, on a Petition for Review of a

decision of the Benefits Review Board, United States Department of Labor, pursuant to 33 U.S.C. § 921(c). A timely petition for rehearing was denied on July 17, 1991.

STATUTES AND REGULATIONS

Section 7(g) of the Longshoremen and Harbor Workers' Compensation Act, 33 U.S.C. § 901, et. seq., (the "Act") provides in pertinent part as follows:

> All fees and other charges for medical examinations, treatment or service shall be limited to such charges as prevail in the community for such treatment, and shall be subject to regulation by the Secretary. The Secretary shall issue regulations limiting the nature and extent of medical expenses chargeable against the employer without authorization by the employer or the Secretary.

33 U.S.C. § 907(g).

The regulations pursuant to Section 7(g) of the Act, in pertinent part, provide as follows:

> §702.413 Fees for medical services; prevailing community charges.
>
> All fees charged by medical care providers for persons covered by this Act shall be limited to such charges for

the same or similar care (including supplies) as prevails in the community in which the medical care provider is located and shall not exceed the customary charges of the medical care provider for the same or similar services. Official state medical fee schedules for workers compensation charges may be used as guidelines in determining the prevailing community rate where available and to the extent appropriate . . .

§702.414 Fees for medical services; unresolved disputes on prevailing charges.

(a) The Director may, upon written complaint of an interested party, or upon the Director's own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies that appears to exceed prevailing, community charges for similar treatment, services or supplies or the provider's customary charges . . . .

(c) After any proceeding under this section the Director shall make specific findings on whether the fee exceeded the prevailing community charges or the provider's customary charges and provide notice of these findings to the affected parties.

§702.415 Fees for medical services; unresolved disputes on charges; procedure.

After issuance of specific findings of fact and proposed action by the Director as provided in §702.414 any affected provider, employer or other

interested party has the right to seek a hearing pursuant to section 556 of Title 5, United States Code. Upon written request for such a hearing, the matter shall be referred by the Deputy Commissioner to the OALJ for formal hearing in accordance with the procedures in Subpart C of this part.

If no such request for a hearing is filed with the duty commissioner within thirty (30) days the findings issued pursuant to §702.414 shall be final.

§702.416 Fees for medical services; disputes; hearing; necessary parties.

At formal hearings held pursuant to §702.415, the necessary parties shall be the person whose fee or cost charge is in question and the Director, or their representatives. The employer or carrier may also be represented, and other parties, or associations having an interest in the proceedings, may be heard, in the discretion of the administrative law judge.

20 C.F.R. §§ 702.413-702.416.

STATEMENT OF THE CASE

This matter arises from a dispute as to the allowable charges for medical care rendered to injured employees pursuant to the Longshoremen and Harbor Workers' Compensation Act, 33 USC §§ 901, et seq. (the "Act").

Newport News Ship Building and Dry Dock Company, Newport News, Virginia, the employer, unilaterally refused to pay a portion of the charges for medical services to Dr. Sidney Loxley[1], an orthopedic surgeon with offices in Virginia Beach and Chesapeake, Virginia, for medical care rendered to some of its employees pursuant to the Act. Dr. Loxley complained to the deputy commissioner of the Department of Labor, who investigated and determined that Dr. Loxley's charges were permissible. (Appendix, p. 67) The employer requested a hearing pursuant to 20 C.F.R. § 702.415.

The case was tried in a de novo hearing before an administrative law judge on October 23, 1986, and on May 27, 1987, he

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[1]Dr. Lawrence D. Bourgard, formerly a member of the same practice as Dr. Loxley, was a named party in the proceedings below. As he has no interest in this matter, he has been omitted from the caption of this case.

issued a decision in favor of the employer. Dr. Loxley appealed to the Benefits Review Board, which reversed the administrative law judge and decided the case in favor of Dr. Loxley, by a decision dated February 28, 1990. The employer appealed to the United States Court of Appeals for the Fourth Circuit pursuant to 33 U.S.C. § 921(c). In a split decision, the Fourth Circuit reversed the Benefits Review Board and upheld the administrative law judge's decision. Newport News Shipbuilding and Dry Dock Company v. Loxley, 934 F.2d 511(4th Cir. 1991) (Widener, J., dissenting). A petition for rehearing was denied on July 17, 1991.

The Act provides a federal workman's compensation program for certain maritime workers as defined in the Act. 33 U.S.C. § 903. Under this program, the employer must provide benefits to such employees for work-related injuries, irrespective of fault. 33 U.S.C. §§ 902(2), 904. In addition to

compensation for death or disability, 33 U.S.C. §§ 908-09, the employer must provide its employees with all medical care required for an injury covered by the Act. 33 U.S.C. § 907(a). The employee has the right to choose his or her doctor, under the supervision of the Department of Labor. 33 U.S.C. § 907(b)-(c). The fees of doctors payable under the Act are "limited to such charges as prevail in the community for such treatment" and are subject to regulation by the Department of Labor. 33 U.S.C. § 907(g).

Dr. Loxley performed the medical care for which charges are disputed for work-related injuries to employees of the employer covered by the Act. (Appendix, p. 65). The disputed charges are for medical procedures described by Current Procedural Terminology (CPT) Codes 90060 (Return Office Visit, Intermediate), 90070 (Return Office Visit, Extended) and 90220 (Hospital Medical Services). The CPT codes

are part of a standardized listing of medical services inaugurated by the American Medical Association in 1966. (Appendix, p. 66).

The employer determined that Dr. Loxley's charges exceeded the fees payable under the Act, which are limited to prevailing community charges for such services. The employer's basis for this determination is that the disputed fees exceeded the benefits payable under the employer's self-insured medical benefits plan negotiated with the Steelworkers Union. In support of its position, the employer presented as evidence of prevailing community charges its statistical basis for computing allowable benefits under its plan. (Appendix, pp. 66-61). The employer used its extensive data data base of medical charges under its plan and computed the 80th percentile of charges from this data base as the allowable charge under its plan and the

prevailing community charge for the CPT codes in question.

For 1985, it used the charges for medical services in 1984. Although Dr. Loxley is an orthopedic surgeon, the employer did not distinguish in its data among medical specialties, including all medical charges for each CPT code, whether rendered by a general practitioner, orthopedic surgeon, or other specialist. (Appendix, pp. 78-80). The employer provided no expert opinion, either from the medical community or as to the statistical validity of its method, to support its position.

The employer has adopted the same methods used by Blue Cross/Blue Shield and Medicare to determine what they will pay as benefits under health insurance programs. (Appendix, pp. 82, 109-10). However, Blue Cross/ Blue Shield, Medicare and the employer's self-insured health plan are all insurance plans which define the benefit

that they will pay, not the doctor's allowable charges. Dr. Loxley is not a participating physician with Medicare or Blue Cross/Blue Shield and is not legally obligated to accept the customary or allowable fee under those programs as his payment in full. (Appendix, p. 71).

Dr. Loxley, with some minimal exceptions of an insignificant percentage of his practice with HMO's, Medicaid and charity patients, does charge the exact same amount for services to all patients, regardless of workman's compensation coverage. (Appendix, pp. 70-71).

The administrative law judge found for the employer, holding that Dr. Loxley bore the burden of proof and had not met it and that the employer's statistical methodology properly defined the prevailing community charges for Dr. Loxley's services. (Appendix, pp. 86-93, 97-115).

On appeal, the Benefits Review Board reversed, holding that the employer, not Dr. Loxley, bore the burden of proof and that the employer's evidence was insufficient to establish the prevailing community charges for the medical services in question. (Appendix, pp. 46-53). The United States Court of Appeals for the Fourth Circuit reversed the Benefits Review Board and upheld the administrative law judge.

ARGUMENT

I. WITHOUT EXPRESS CONGRESSIONAL AUTHORITY, COURTS CANNOT ADOPT THE ALLOWABLE MEDICAL CHARGES UNDER AN EMPLOYER'S HEALTH BENEFIT PLAN AS A MANDATORY FEE SCHEDULE IMPLEMENTING THE PREVAILING RATE LIMITATION ON MEDICAL FEES UNDER THE LONGSHOREMEN AND HARBOR WORKERS' COMPENSATION ACT.

This case involves an issue of national importance as it is the only reported judicial decision construing the prevailing rate limitation on medical fees under the Act. Although the majority opinion of the

court of appeals is stated as upholding the factual determination of the administrative law judge, in actuality it stands for the principle that the prevailing rate allowable under the Act for medical services is determined by the amount of benefit payable under an employer's health insurance plan. Any employer covered by the Act will have access to a data base such as NNS's, either within its own self-insurance program or from its insurer. Furthermore, this data will have with it, by contract, a percentile rate of payable benefit, just as in this case. The lower court has ruled that, as a matter of law, this type of statistical data defines the prevailing rate for medical services under the Act. Therefore, it authorizes any employer covered by the Act to implement its own mandatory fee schedule, a power that Congress has granted only to the Secretary of Labor. 33 U.S.C. § 907(g).

The Act grants to the Secretary of Labor the authority to regulate medical fees to enforce the limitation to prevailing community charges. 33 U.S.C. § 907(g). The Secretary of Labor has not adopted a comprehensive fee schedule.[2]

The administrative law judge apparently perceived this as a significant failure on the part of the Secretary of Labor. In finding that the employer's evidence was persuasive, he cited with approval the publication of medical fee price lists in order to reduce medical costs and as beneficial in solving the "problem abroad in the land." (Appendix, p. 107) The administrative law judge, by approving evidence of third party payment practices as compelling evidence of prevailing community charges, and the court

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[2]The Secretary of Labor has authorized use of official state medical fee schedules as guidelines, 20 C.F.R. § 702.413, but Virginia has not adopted an official fee schedule.

of appeals by sustaining him, have provided mandatory fee schedules for all claims covered by the Act in the face of the failure of Congress and, by delegation of this power, the Secretary of Labor, to promulgate a fee schedule. In other words, the judiciary has perceived a void left by Congress and has proceeded to correct this "omission" by judicial fiat.

This Court, however, has consistently rejected such judicial attempts to fill a perceived void left by Congress and has required the federal courts to follow the exact Congressional mandate, even where the results are not in accord with the judiciary's preferences or ideas of sound public policy. Rodriquez v. Compass Shipping Co., Ltd., 451 U.S. 596 (1981) (third party claims of injured employee automatically assigned to employer under LHWCA regardless of employer's failure to prosecute under specific language of the statute); Potomac

Electric Power Co. v. Director, Office of Workers' Compensation Programs, 449 U.S. 268, 273, 280, 284 (1980) (Court cannot give injured employee higher benefit than scheduled under the LHWCA because of anomalous result under specific language of statute); see also H.K. Porter Co., Inc. v. NLRB, 397 U.S. 99, 109 (1970)(remedial powers granted NLRB by Congress limited under statute even if perceived to be insufficient).

Under his Congressional mandate, instead of establishing a comprehensive mandatory fee schedule, the Secretary of Labor has opted for a relatively simple and effective safeguard against abuse under the Act in the second part of the test stated in the regulations, that a doctor's charges under the Act must be the same as he charges other patients for the same services. 20 C.F.R. § 702.413. The decision of the Court of Appeals and the administrative law judge, on

the other hand, ignore this simple procedural safeguard and attempt to fill the perceived void left by the Secretary's failure to adopt a mandatory rate schedule, but without Congressional authority to do so.

The method used by the employer to establish its fee schedule in this case is inherently arbitrary. Such arbitrariness is permissable, and indeed necessary, in establishing benefits payable under an insurance plan or, should Congress or the Secretary of Labor in the exercise of his authority granted by Congress decide to do so, in establishing a fee schedule under the Act. As the employer has not been granted such authority by Congress, it cannot use an arbitrary method in determining prevailing community charges for medical services under the Act.

The arbitrary elements of the employer's methods are what the Benefit Review Board focused on in determining that the employer's

evidence, as a matter of law, failed to establish its fee schedule as the prevailing community charged. These elements are the arbitrary choice of the 80th percentile of all billings, the use of the prior year's data to set the rates, and the failure to distinguish rates on the basis of medical specialization. Moreover, as the Board noted, the failure to distinguish on the basis of medical specialization violates the Act because it specifically requires that the standard be for "the same or similar" care. 33 U.S.C. § 907(g).

Thus, the acceptance by the administrative law judge of the employer's legally flawed and unresponsive evidence, and the upholding of his decision by the court of appeals, result in a violation of the express provisions of the Act and the Congressional scheme for regulating medical charges under the Act.

II. THE LOWER COURT ERRED IN ALLOCATING THE BURDEN OF PROOF TO DR. LOXLEY BECAUSE NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY IS THE PROPONENT OF AN ORDER DISALLOWING HIS FEES.

In an administrative proceeding, the proponent of an order bears the burden of proof. 5 U.S.C. § 556(d). The Benefit Review Board properly allocated the burden of proof to the employer and cited the applicable regulation governing such disputes, which provides that such a case arises upon written complaint of an interested party that fees are excessive. 20 C.F.R. § 702.414(a).

The Court of Appeals allocated the burden of proof to Dr. Loxley based upon a misunderstanding of this governing regulation. Its opinion paraphrased this regulation, stating that it provides: "If an employer refuses fully to compensate a physician for medical care provided under the Act, the physician can request the Director for the Office of Workers' Compensation

Programs ("the Director") to investigate the unpaid charges. 20 C.F.R. §§ 702.407(b), 702.414(a) (1990)." It concluded that, as Dr. Loxley initiated the proceedings, he is the one seeking to establish the affirmative of the issue, that his charges did not exceed prevailing community charges, and therefore he bears the burden of proof.

The actual text of the regulation is different from the Court of Appeal's description. It states:

> The Director may, upon written complaint of an interested party, or upon the Director's own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies that appears to exceed prevailing, community charges for similar treatment, services or supplies or the provider's customary charges. . . .

20 C.F.R. § 702.414(a) (emphasis added).[3]

The Benefit Review Board relied on this

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[3]20 C.F.R. § 702.407(b) provides that among the Director's duties to supervise medical care under the Act is the duty to determine whether charges for medical care exceed those permitted under the Act.

regulation to conclude that NNS bears the burden of proof. In other words, the employer is an "interested party" that has complained that Dr. Loxley's fees exceed the prevailing community rate by refusing payment. Therefore, it is the party seeking the affirmative of the issue and bears the burden of proof. 5 U.S.C. § 556(d).

That Dr. Loxley actually initiated the complaint to the Director does not change the result of this analysis. The prevailing community rate standard of 33 U.S.C. § 907(g) is implemented in 20 C.F.R. §§ 702.413-702.417, and these regulations provide the procedural mechanism for resolution of fee disputes between employer and provider. Accordingly, § 702.414(a) is the only basis for allowing the employer to challenge Dr. Loxley's fees. It authorizes the Director to investigate a complaint of excessive fees, and does not provide a mechanism for assistance in collecting these fees. The

complaint in this case is the employer's unilateral action in refusing full payment, thereby ignoring the regulation's requirement of a written complaint to lawfully contest the fees. Therefore, the employer is the legal complainant. To hold otherwise would be to ignore the regulations and to accord the employer a substantial procedural advantage for its unauthorized method of asserting its complaint.

In summary, the legal analysis of both the lower court and of the Benefits Review Board in this case is the same. The difference in conclusions results from the different understandings of the regulation that defines the proponent of the order in this case. The lower court's conclusion is incorrect because of its misunderstanding and misapplication of the regulation. Section 702.414(a) actually provides that medical fee disputes are initiated by a complaint that the fees are excessive, and therefore the employer, which

in this case is complaining that Dr. Loxley's fees are excessive, is the proponent of the order, seeking to establish the affirmative of the issue. Therefore, the employer bears the burden of proof. See 5 U.S.C. § 556(d).

Allocation of the burden of proof in this case is significant, even though Dr. Loxley's primary argument in this Petition is that the employer's fee schedule is illegal. The administrative law judge found that Dr. Loxley's evidence was insufficient to establish prevailing community charges.[4] As the employer's evidence is legally insufficient to establish its position, the narrow issue of recovery of the disputed fees necessarily must turn on which party bears the burden of proof.

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[4]Dr. Loxley presented the only direct evidence of the prevailing community charges for his services, the testimony of another orthopedic surgeon practicing in the same geographic area, which orthopedic surgeon was also chairman of the Virginia Medical Cost Peer Review Industrial Commission. (Appendix, pp. 57-60).

CONCLUSION

The United States Court of Appeals for the Fourth Circuit has in this case decided an important question of federal law, the power of an employer to impose its own fee schedule for medical services under the Longshoremen and Harbor Workers' Compensation Act, in a way that conflicts with applicable decisions of this Court. This issue must ultimately be settled by this Court

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APPENDIX

Opinion of the United States Court of Appeals, for the Fourth Circuit dated May 21, 1991 1

Decision and Order of the Benefits Review Board, United States Department of Labor, dated February 28, 1990 29

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UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 90-1449

NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY,

Petitioner,

versus

DR. SIDNEY S. LOXLEY; DR. LAWRENCE D. BOURGARD; DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,

Respondents.

On Petition for Review of an Order of the Benefits Review Board.

Argued: December 3, 1990

Decided: May 21, 1991

Before WIDENER and WILKINS, Circuit Judges, and MICHAEL, United States District Judge for the Western District of Virginia, sitting by designation.

Reversed by published opinion. Judge Michael wrote the majority opinion, in which Judge Wilkins joined. Judge Widener wrote a dissenting opinion.

ARGUED: Lawrence Philip Postol, SEYFARTH, SHAW, FAIRWEATHER & GERALDSON, Washington, D.C., for Petitioner. John Lucian Smith, Jr., OUTLAND, GRAY, O'KEEFE & HUBBARD, Chesapeake, Virginia, for Respondents. **ON BRIEF:** Michael S. Hertzig, Office of the Solicitor, UNITED STATES DEPARTMENT OF LABOR, Washington, D.C., for Respondents.
MICHAEL, District Judge:

The Newport News Shipbuilding and Dry Dock Company ("NNS") appeals from an Order of the United States Department of Labor Benefits Review Board pursuant to Section 21 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C.A. 921 (West 1986) ("the Longshore Act"). Because we find that the Administrative Law Judge's decision was supported by substantial evidence, we reverse the decision of the Benefits Review Board.

I.

The parties' dispute arose over payment for medical services which Dr. Loxley rendered to NNS employees. Under the Longshore Act, workers can select their own doctor; however, the Act limits the Employer's liability for the ensuing medical charges to the "prevailing rate."[1] Because neither the Act nor its regulations define "prevailing rate, " NNS computed this rate pursuant to the methodology it used in its self-insured health benefit plan. Finding that Loxley's charges on three particular services exceeded the prevailing rate, NNS refused to reimburse Loxley in full.

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[1] The Act limits fees payable "to such charges as prevail in the community for such treatment. " 33 U. S. C.A. § 907 (g) (West 1986). Under the governing regulation, such charges "shall not exceed the customary charges of the medical care provider for the same or similar services. " 20 C.F.R. 5 702.413 (1990).

The issue before the administrative law judge was whether Loxley's charges were within the prevailing rate limitation pursuant to section 7 of the Act. At the hearing, NNS introduced evidence explaining that it determined the prevailing rate by using figures from its health benefits plan, a plan which was negotiated with the Shipyard Union and covers some 77,000 workers and dependents. Under this plan, NNS agreed to pay the insured medical charges in full if the fee for a specified service, defined by CPT codes[2] did not exceed the 80th percentile of charges for

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[2] The services at issue are coded according to the Current Procedural Terminology (CPT), a uniform coding used in "identifying, describing, and coding medical, surgical, and diagnostic services performed by practicing physicians." A.M.A. Physicians' Current Procedural Terminology at iii (4th ed. 1986). The coding system is "the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs." Id.

that particular service.[3] NNS incorporated this plan into its determination of the prevailing rate under the Longshore Act by using the 80 percent figure as the prevailing rate. Thus, when Loxley's charges exceeded its calculations of the prevailing rate for three CPT codes, NNS paid him only the amount represented by the 80th percentile.

At the administrative hearing, Loxley tendered his own testimony and that of Dr. Taylor, his expert. Besides admitting that he did not know what he, or other doctors in the area, charged for the disputed CPT codes, Loxley also presented no data which challenged use of the 80th percentile standard by NNS. Likewise, Dr.

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[3] Using charges for specific CPT codes which were submitted under its health benefits plan during the previous year, NNS calculated the amount below which 80 percent of the charges fell. NNS reimbursed in full only those fees at or below the 80th percentile.

Taylor could not give either his charges or an estimate of the prevailing rate for the services at issue. Although he testified that Loxley's fees were fair, he conceded that he did not know the rates of other doctors and, without such information, he could not disagree with the Employer's statistical analysis. Moreover, Taylor stated that he had no problem with the Shipyard's use of the 80th percentile to determine the prevailing rate, although he thought its results were low. Taylor did offer some insight by explaining that the fees of specialists and generalists should not be computed in the same statistical base. NNS does not differentiate by specialty in computing the prevailing rates for the various CPT codes. However, in his testimony, Taylor could not articulate a method by which NNS could reasonably differentiate by specialization.

After hearing all of the evidence, the administrative law judge wrote an extensive opinion concluding that Dr. Loxley's charges exceeded the prevailing rate. He indicated that "the testimony of Drs. Loxley and Taylor fell far short of establishing that Dr. Loxley's charges fall within the [prevailing community rate]."

The Benefits Review Board ("the Board") reversed the administrative law judge's decision and disregarded his findings of fact. The Board disagreed with the lower court's determination that Loxley, as the proponent of an order requiring that NNS pay his charges in full, bore the burden of proof on the prevailing rates issue. After holding that NNS carried the burden of proof, the Board further disagreed with the administrative law judge's statement that, even if the burden fell on NNS, the employer had in fact met its burden. The Board concluded that "the employer's evidence is

wholly insufficient to establish prevailing community charges for the medical services performed by Dr. Loxley."

II.

According to section 21 of the Longshore Act, the standard of review for an administrative law judge's decision is whether the record contains sufficient evidence to support the decision. If the evidence meets this standard, the administrative law judge's findings of fact are "conclusive upon the Board" and "the Board is not free to disregard them or draw other inferences which it thinks may be more reasonable." Newport News Shipbuilding & Dry Dock Co. V. Director, 681 F.2d 938 (4th Cir. 1982).

Reserving for the moment the issue of which party bore the burden of proof, we will first examine whether the Board exceeded its powers of review by disregarding the administrative law judge's

findings of fact. Contrary to the administrative law judge's determination that its conclusion would have been the same even if NNS carried the burden of proof, the Board found the employer's evidence lacking. We do not agree with the Board's interpretation of the evidence presented at the hearing, and we find that the Board erroneously expanded its scope of review by its independent analysis of the facts.

Contrary to the rule that the administrative law judge's findings of fact are conclusive upon the Board, the appellate panel nonetheless attacked the conclusion that the process by which NNS determined the prevailing rate was adequate. The Board found the evidence submitted by NNS lacking in several respects. First, the Board found that the data offered by NNS did not "represent a true sample of medical fees charged by physicians practicing in the community." The record shows, however, that

NNS made a broad survey of fees which included at least 46,700 charges submitted by approximately 70 percent of the doctors in the Hampton Roads area. That NNS utilized data from its negotiated health benefits plan is of no consequence. Citing the Act's provision that the employer shall furnish all medical, surgical, and other related treatment, 33 U.S.C.A. § 907(a) (West 1986), the Board concluded that using the 80th percentile to determine the prevailing rate did not satisfy the Act's requirements. However, the Board's analysis neglects provisions in the Act and the regulations that an employer's obligation for medical charges is limited to the prevailing rate. Id. at § 907(g); 20 C.F.R. § 702.413 (1990).

The Board also found that the survey of fees by NNS was "inherently flawed" because it did not distinguish on the basis

of medical specialization. Focusing on provisions in the Act and regulations which dictate that the prevailing rate should be measured by charges for "the same or similar care, " 33 U.S.C.A. § 907(b), (g) (West 1986); 20 C.F.R. §§ 702.413, 702.414 (1990), the Board criticized NNS for relying solely on the use of CPT codes to compare fees. The Board noted that without evidence that the services performed by other physicians whose charges made up the data base did in fact constitute the same or similar care as that rendered by Loxley, NNS could not sustain its burden under the Act. Based on the evidence produced at the hearing,[4] the

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[4] The evidence on this point included Taylor's testimony that orthopedic surgeons' charges differ from those of other specialists or primary care physicians for the services that fall within the same CPT codes, and documents submitted by NNS showing that other carriers, such as Blue Cross Blue Shield, do not differentiate by specialists.

administrative law judge found unpersuasive Loxley's challenge that NNS should have limited its data to the fees of physicians practicing his specialty, orthopedic surgery. We agree. Although the evidence showed that in two of the three CPT codes involved, the prevailing rate figure was actually higher when NNS used the entire pool of charges than when it measured only the charges of orthopedic surgeons,[5] we find

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[5] For the purposes of the hearing, NNS conducted a survey of fees submitted only by "specialists" to its health care plan. NNS defined "specialists" by selecting names listed under "orthopedic surgeons" in the yellow pages. The results of this survey indicated that the rate at the 80th percentile for the specialists charges was below the same rate calculated with respect to all fees submitted in two of the three CPT codes at issue.

We do not base our conclusion that differentiation by specialty is not mandated by the Act on the results of this second survey by NNS. The Board disregarded the survey, stating that it was insufficient because it was limited to those charges submitted to the NNS health benefit plan. We simply find that the results of the survey are immaterial as the nature of the services performed, not the status of the medical care provider, are relevant in

that making a distinction between lists and specialists is not necessary.

A series of factors supports this conclusion. First, the CPT codes were designed by the medical profession as a uniform reference to designate medical, surgical and diagnostic services. The codes do not differentiate by specialist. That each code encompasses "same or similar" services is apparent from their very definitions. Furthermore, the Act and regulations discuss comparable treatment; they do not distinguish between medical providers.[6] The Board concluded that NNS should use a separate data base for

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[6] See 33 U.S.C.A. § 907(g) (West 1986) ("All fees ... shall be limited to such charges as prevail in the community for such treatment...."); 20 C.F.R. § 702. 413 (1990) ("All fees ... shall be limited to such charges for the same or similar care (including supplies) as prevail in the community... and shall not exceed the customary charges of the medical care provider for the same or similar services."); and 20 C.F.R. § 702.414 (1990) (discussing "similar treatment").

specialists; however, it did not define specialist and ignored evidence in the record indicating that no such definition is practically available.[7] Because we find that use of the CPT codes is sufficient to define "same or similar care" under the Act, we hold that the employer need not differentiate between generalists and specialists in determining the prevailing rate.

We also find improper the Board's statement that NNS did not submit evidence

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[7] At the hearing, Taylor indicated the difficulty in defining "specialist." Although he indicated that one determining factor would be whether a physician was "Board-certified" or "Board-eligible," he stated that if he had to determine who in the area was "Board-eligible," he would "Simply go around and talk to people." The burdensome task of defining "specialist" is, moreover, unnecessary, given the fact that the CPT code system allows for the use of modifiers which help to distinguish a type of medical care. By using a modifier, a physician can indicate that a particular service was altered in some respect even though its code number was not changed. See A.M.A. Physicians' Current Procedural Terminology at xi-xiii (4th ed. 1986)

demonstrating the charges to patients in the relevant geographical area who are covered under any other type of plan. The data used by NNS included over 46,700 charges made by approximately 1700 doctors; this represents greater than 70% of the physicians in the applicable geographic area. If the Act's prevailing rate limitation demands that an employer conduct a more-encompassing survey of medical fees, then even employers such as NNS, which has an unusually large amount of resources at its disposal, would face a cumbersome, indeed prohibitive, burden. Although we note the Board's objection to the use of the previous year's rates as a basis for the current year's billings[8] we do

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[8] Use of the prior year's rates does not account for the effects of inflation or other factors which might increase fees. However, as the administrative law judge noted, Blue Cross Blue Shield also uses rates from the previous year, in what is the most practicable way to establish such rates. Trying to do so on a monthly, or other short-term, basis could well not produce enough billing to constitute a valid sample.

not think that this factor alone can undermine the methodology employed by NNS.

Because the Act and regulations give no guidance on how to ascertain the prevailing rate, employers must devise their own means of doing so. Absent more definitive directions for determining the prevailing rate, we believe that an administrative law judge's conclusion that the employer met its burden of defining such a rate should be given great credence by the Board. The evidence submitted at the hearing sufficiently supported the finding of the administrative law judge that NNS sustained its burden of proving the prevailing rates.

III.

The administrative law judge found that Dr. Loxley carried the burden of proving that his rates were within the Act's prevailing rate limitation. The Board reversed, assigning the burden to the Employer. Because we affirm the conclusion

of the administrative law judge that Loxley's charges exceeded the prevailing rate regardless of who carried the burden of proof, we need not decide on whom the burden falls in disposing of this appeal. However, the parties have properly raised the issue and, finding it in the better interests of the parties to resolve the matter, we hold that a physician who seeks an order compelling full payment of his charges carries the burden of proof at the administrative hearing.

The regulations under the Act provide as follows: If an employer refuses fully to compensate a physician for medical care provided under the Act, the physician can request the Director of the Office of Workers' Compensation Programs ("the Director") to investigate the unpaid charges. 20 C.F.R. §§ 702.407(b), 702.414(a) (1990). Upon such investigation, the Director makes a finding on "whether the

fee exceeded the prevailing community charges or the provider's customary charges" and advises the parties of his decision. Id. at § 702.414(c). If a party disputes this finding, it has a right to request an administrative hearing pursuant to 5 U.S.C. § 556. Id. at § 702.415. The necessary parties at such a hearing include "the person whose fee or cost charge is in question and the Director, or their representatives. The employer or carrier may also be represented ... in the discretion of the administrative law judge." Id. at § 702.416.

Neither Section 7 of the Act nor the regulations assign the burden of proof at the administrative hearing. However, for the following reasons we find that the burden is on the physician claiming that his charges are within the prevailing community rates. As the Board properly noted, under section 702.415 a party may request an

administrative hearing pursuant to 5 U.S.C. § 556. Therefore, subsection (d) of that provision, which states "Except as otherwise provided by statute, the proponent of a rule or order has the burden of proof", is applicable. This placing of the burden of proof is consistent with the traditional common law rule, noted by the administrative law judge, that the proponent - the one who seeks to establish the affirmative of an issue - carries the burden of proof. Selma, Rome & C. Railroad v. United States, 139 U.S. 560, 567 (1891); Flemino v. Harrison, 162 F.2d 789, 792 (8th Cir. 1947).

Although the Board identified the proper rule regarding the burden of proof, it incorrectly applied the rule. Holding that NNS was "the proponent of an order ruling that Dr. Loxley's medical fees exceed the prevailing community charges," the Board assigned the burden to NNS. We find the administrative law judge's analysis more

compelling. From a procedural perspective, the fact that NNS requested the hearing does not, ipso facto, make it the proponent of the issue. The request for an administrative hearing by NNS was not, nor do the regulations provide for, an appeal from the finding of the Deputy Commissioner. Rather, the administrative hearing is a de novo proceeding which examines the same issue confronted by the Deputy Commissioner. This fact compels us to make two observations: First, it was Loxley, not NNS, who initiated proceedings to clarify whether his rate was within the prevailing rate. Thus, the issue before the administrative law judge was raised by Loxley, not NNS. Second, as the administrative law judge noted, to hold that NNS carried the burden of proof at the hearing would effectively accord "a presumption of correctness to the Deputy Commissioner's ruling - an approach antithetical to the concept of a de novo

hearing" before the administrative law judge. The regulations which govern the administrative hearing before the administrative law judge also support these conclusions. Section 702.416, a provision which the Board did not address in reaching its conclusion, states that "[a]t formal hearings held pursuant to § 702. 415, the necessary parties shall be the person whose fee or cost charge is in question and the Director, or their representatives." The language of this regulation gives credence to our conclusion that one of the "necessary parties" must bear the burden of proof, and that language identifies a "necessary" party as "the person whose fee or cost charge is in question." Whether the burden is assigned to "the Director" or to the "person whose fee or cost charge is in question" under the portion of the regulations, it is a reasonable conclusion that such burden is not assigned to one in the position of NNS.

In making this conclusion as to the burden of proof, we do not purport to determine how a physician should or could sustain this burden at an administrative hearing. In the context of the record before us, however, we find that Loxley did not offer sufficient evidence to prove that his charges fell within the prevailing rate. As previously discussed, Loxley offered little if any useful information as to what constitutes the prevailing rate. At the hearing, he did not offer any evidence attacking the methodology used by NNS. Although Taylor testified that he thought the resulting prevailing rates were low, when asked whether he "had a particular problem" with the use of the 80th percentile, he responded, "I don't, personally, and I don't think the peer review group has any problem with that." Taylor commented that NNS should inform physicians in the area of its practice in determining the prevailing rate,

but he testified that he could not dispute the documentation underlying NNS's statistical analysis. At the hearing, counsel for Loxley was willing to stipulate that "Dr. Loxley has not made an exhaustive statistical analysis, and I further stipulate that it would be illegal for him to do so." The only testimony Loxley and Taylor submitted against the NNS determinations of the prevailing rate was their respective comments, unsupported by any evidence, that Loxley's fees were fair.

Upon hearing the testimony and examining the evidence, the administrative law judge was not persuaded by Loxley's attempt to show that his rates were within those that prevailed in the community. We find that the record contained sufficient evidence to support the findings of fact of the administrative law judge which thus became "conclusive upon the Board." The Board

erred in disregarding these findings of fact.

For the reasons indicated, the judgment of the Board is

REVERSED.

WIDENER, Circuit Judge, dissenting:

I respectfully dissent.

I would affirm on the opinion of the Benefits Review Board, which I find it difficult to improve upon.

I here highlight certain parts of that opinion to annunciate my differences with the majority.

First. The setting of this case is that Newport News, the employer, refused to make payment in full for bills submitted in 1985 for treatment of work-related injuries sustained by ten of its employees.

Second. As a result of this non-payment, Dr. Loxley complained to Deputy Commissioner B.A. Voultsides, who initiated

an investigation on the unpaid charges. In the course of his investigation, the Deputy Commissioner requested the opinion of Dr. Jervis S. Taylor, an orthopaedic surgeon and Chairman of the Medical Peer Review Committee of the Eastern Virginia Area, as to the appropriateness of the fees charged by Dr. Loxley. Dr. Taylor's response to the Deputy Commissioner was that he was of the opinion that the charges were low or low/normal. The Deputy Commissioner subsequently advised Newport News that he found Dr. Loxley's charges to be appropriate as reasonable charges in the community where he practices and recommended that payment be made in full.

Third. Newport News then requested a hearing challenging the Deputy Commissioner's determination that the fees charged do not exceed the prevailing community rate.

Fourth. Thus, Newport News was the moving party in this case and properly assigned the burden of proof under 5 U.S.C. § 556(d), which provides in pertinent part that "the proponent of a rule or order has the burden of proof." Since Newport News is the proponent of an order deciding that the Deputy Commissioner's ruling was in error, it is at once apparent to me that it had the burden of proof and that the Benefits Review Board properly assigned the burden to Newport News.

Fifth. Newport News and the Steel Workers Union agreed by contract that the employer would only pay the prevailing rate for physicians' fees, which the contract defined as the 80th percentile of those fees. But Newport News used a data base of all physicians' fees, not physicians' fees of orthopaedic surgeons, of which specialty Dr. Loxley was a member. Thus, the fees which Newport News was willing to pay to Dr.

Loxley for medical care, I think, were patently in violation of 33 U.S.C. § 907(g), which provides that such charges are limited "to such charges as prevailing in the community for such treatment," and 20 C.F.R. § 702. 413, which provides that the physician's fees "shall not exceed the customary charges of the medical care provider for the same or similar services."

While it is true that under § 907(g) a physician's charges are subject to regulation by the Secretary, it is not true that physicians' charges are subject to regulation by Newport News and the employees' union. The Secretary has not regulated the same. Indeed, it does not require any stretching to find that the decision of the Deputy Commissioner, that Dr. Loxley's fees met statutory and regulatory requirements, is an administrative action presumed to be regular and not subject to overturning except for

the most extraordinary reasons not present here.

I have attached a copy of the decision of the Benefits Review Board to this opinion and subscribe to it.

U.S. DEPARTMENT OF LABOR
Benefits Review Board
1111 20th Street, N.W.
Washington, D.C. 20036

PUBLISHED

BRB No. 87-1666

DR. SIDNEY S. LOXLEY	)	
	)	
and	)	
	)	
DR. LAWRENCE D. BOURGARD	)	
	)	
Health Care Providers-Petitioners	)	
	)	
v.	)	
	)	
NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY	)	
	)	
Self-Insured Employer-Respondent	)	DECISION and ORDER

Appeal of the Decision and Order of John C. Bradley, Administrative Law Judge, United States Department of Labor.

John L. Smith, Jr. (Outland, Gray, O'Keefe & Hubbard), Chesapeake, Virginia, for the health care providers.

Lawrence P. Postol (Seyfarth, Shaw, Fairweather & Geraldson), Washington, D.C., for the self-insured employer.

Before: BROWN, DOLDER, and McGRANERY, Administrative Appeals Judges.

PER CURIAM:

Dr. Sidney S. Loxley and Dr. Lawrence D. Bourgard appeal the Decision and Order (86-LHC-1235; 86-LHC-1232; 86-LHC-1227; 86-LHC-1233; 84-LHC-1644; 85-LHC-1760; 86-LHC-1229; 86-LHC-789; 86-LHC-1234; 86-LHC-1248) of Administrative Law Judge John C. Bradley rendered pursuant to the provisions of the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901 et seq. (the Act). Pursuant to the Board's Order dated August 31, 1989, oral argument was held in Norfolk, Virginia, on October 11, 1989.

The sole issue on appeal is whether the administrative law judge properly determined that the fees charged by Dr. Loxley and his associate Dr. Bourgard (hereinafter, collectively referred to as Dr. Loxley), orthopedic surgeons who rendered medical service to injured employees pursuant to the Act, exceed the prevailing community charges

for the same or similar services in violation of the Act. See 33 U.S.C. §907(b), (g) (Supp. V 19867); 20 C.F.R. §§ 702.413-702.417. We must affirm the findings and conclusions of the administrative law judge which are rational, supported by substantial evidence, and in accordance with law. 33 U.S.C. 5921(b)(3); O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc., 380 U.S. 359 (1965).

The instant appeal arises from a dispute concerning charges for medical services rendered by Dr. Loxley to injured employees pursuant to Section 7 of the Act, 33 U.S.C. §907.[1] The record establishes that employer refused to make payment in full for bills submitted in 1985 for treatment of work-related injuries sustained by ten of

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[1] The parties stipulated that Dr. Loxley did, in fact, perform the services for which charges were submitted and that the medical services rendered were for work-related injuries.

employer's employees. Employer disputed Dr. Loxley's charges for three types of services coded according to the Current Procedural Terminology (CPT), a uniform coding of procedures and services performed by physicians, adopted by the American Medical Association and utilized by Dr. Loxley. At issue in this case are Dr. Loxley's charges for services described by the following three CPT Codes:

CPT Code	Description of Service
90060	Office Services, Established Patient, intermediate
90070	Office Services, Established Patient, extended.
90220	Initial Hospital Care, Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records.

Rather than paying Dr. Loxley's charges in full, employer paid Dr. Loxley only what it determined to be the prevailing rate for such services. In making its determination

as to what was an appropriate prevailing community charge, employer adopted medical fee data from its self-insured health benefit plan for its employees and their dependents. Under its health benefit plan, employer pays only the prevailing rate, defined as the 80th percentile, or the level at which 80 percent of the medical charges received by the insurance plan for a particular service are below. In extending its self-insured health benefit plan's prevailing rate limitation to medical charges in compensation claims, employer utilized survey data on the fees charged in 1984 by physicians in the community for the three relevant CPT Codes in insurance claims submitted to employer's health benefit plan. Employer's data base does not distinguish among physicians on the basis of medical specialty; thus, the 80th percentile prevailing rate is based on charges submitted by all physicians across the board

and is not confined to charges submitted by only those physicians practicing a particular medical specialty. Employer accordingly compiled data on medical charges submitted to its health benefit plan for services described by CPT Codes 90060, 90070, and 90220,[2] calculated the 80th percentile for each of those CPT Codes, and paid Dr. Loxley only the amount represented by the 80th percentile.[3]

After being advised that employer would not make payment in full, Dr. Loxley contacted Deputy Commissioner B.E.

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[2] Dr. Loxley's charges and payment received are as follows:

CPT Code	Dr. Loxley's Charge	Employer's Payment
90060	$ 38.50	$ 25.00
90070	52.00	35.00
90220	122.00	110.00

[3] Employer's data base includes approximately 1,700 physicians. The survey includes 38,792 charges for CPT Code 90060, 4,834 charges for CPT Code 90070, and 3,097 charges for CPT Code 90220.

Voultsides, who initiated an investigation of the unpaid medical charges. See 20 C.F.R. 5702.407, 702.414(a). In the course of his investigation, the deputy commissioner requested the opinion of Dr. Gervas S. Taylor, an orthopedic surgeon and chairman of the Medical Peer Review Committee for the Eastern Virginia Area, as to the appropriateness of the fees charged by Dr. Loxley. Dr. Taylor responded that each of the charges was normal or low/normal. The deputy commissioner subsequently advised employer that he found Dr. Loxley's charges to be appropriate as reasonable charges in the community where he practices and recommended that payment be made in full. See 20 C.F.R. §702.414 (c).

Employer requested a hearing, challenging the deputy commissioner's determination that the fees charged do not exceed the prevailing community rate. See 20 C.F.R. §702.415. Subsequent to the referral for

hearing, employer compiled additional fee data in an attempt to extract charges by orthopedic surgeons for the relevant CPT Codes. After an unsuccessful attempt to obtain a list of Board-certified and Board-eligible orthopedic specialists from local medical societies, employer relied on the listing of orthopedic surgeons in the Peninsula and Norfolk telephone directory yellow pages. Employer isolated the fee data on these orthopedic surgeons contained in its original data base of physicians who had submitted bills under employer's health benefit plan for services described in the relevant CPT Codes[4] and applied the 80th percentile limitation to the charges of those orthopedists.[5]

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[4] The subsequent survey of orthopedic surgeons contains 520 charges for CPT Code 90060, 650 charges for CPT Code 90070, and 74 charges for CPT Code 90220.

[5] Employer's fee data on orthopedic surgeons are as follows:

In his Decision and Order issued May 27, 1987, the administrative law judge noted that fees for medical care rendered under the Act must meet a dual standard, in that they "shall be limited to such charges for the same or similar care. .. as prevails in the community in which the medical care provider is located" and "shall not exceed the customary charges of the medical care provider for the same or similar services." See 20 C.F.R.§ 702.413.[6] Noting that the

CPT Code	Dr. Loxley's Charge	Amount Paid by Employer	80th Percentile Orthopedic Surgeons' Fees
90060	$ 38.50	$ 25.00	$ 30.00
90070	52.00	35.00	30.00
90220	122.00	110.00	100.00

[6] It is noted that the administrative law judge in the instant case found that Dr. Loxley's charges exceeded the prevailing community rate, the first prong of the standard, not that they exceeded his customary charges, the second prong. Employer does not contend on appeal that the administrative law judge also should have found that Dr. Loxley's charges exceeded his customary charges.

statute does not address the question of which party bears the burden of proof with respect to whether a medical fee exceeds the prevailing community rate, the administrative law judge determined that such burden lies with the health care provider. The administrative law judge next determined that "community" was properly defined by employer as the area used by employer in its self-insured health benefit plan.[7] The administrative law judge rejected Dr. Loxley's contention that employer's determination of prevailing community rates is flawed by employer's failure to distinguish among medical specialists, noting that when employer enlarged its original survey data base to break out specific fee data regarding orthopedic surgeons, the result was that Dr.

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[7] The definition of "community" applied by the administrative law judge is not challenged by Dr. Loxley on appeal.

Loxley was paid more for services under two of the three CPT Codes using the general survey data than he would have been paid if employer had considered only the data concerning orthopedic surgeons. Having found unpersuasive the testimony of both Drs. Loxley and Taylor concerning prevailing community rates, the administrative law judge ultimately found that Dr. Loxley failed to sustain his burden of proof that his fees were reasonable. Finding that employer's evidence was persuasive, the administrative law judge noted that the end result would have been the same even had he found that employer had the burden of proof. The administrative law judge rejected Dr. Loxley's argument that employer's fee schedule violates an employee's right pursuant to Section 7 (b) of the Act, 33 U.S.C. §907 (b), to choose his attending physician, stating that such right is, by statute, not without exception. The

administrative law judge, accordingly, concluded that employer's use of the 80th percentile method is a satisfactory standard for determining prevailing community rates, that the methodology used to establish the 80th percentile was appropriate, and that employer demonstrated that Dr. Loxley's charges exceed the prevailing community rates.

On appeal, Dr. Loxley contends that employer's definition of prevailing community charges is arbitrary and constitutes an unauthorized and illegal mandatory fee schedule; that the administrative law judge erroneously found that Dr. Loxley bears the burden of proof as to whether a medical charge exceeds the prevailing community charge; that the administrative law judge's finding that Dr. Loxley's charges exceed prevailing community rates is not supported by substantial evidence; and that the administrative law

judge erroneously found it unnecessary to distinguish between fees charged by orthopedic surgeons and fees charged by other physicians in determining prevailing community rates. Employer responds that the administrative law judge's Decision and Order should be affirmed.[8]

The relevant provisions of the Act are as follows:

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[8] Dr. Loxley, in his reply brief, contends that the statement of facts contained in employer's response brief misrepresents Dr. Taylor's hearing testimony. We agree. First, Dr. Loxley correctly asserts that, contrary to employer's contention that Dr. Taylor changed his opinion as to the charge for an intermediate office visit, the record is clear that the confusion over this charge was due to an error on the part of the deputy commissioner. Next, as pointed out by Dr. Loxley, employer's conclusion that Dr. Taylor was of the opinion that physicians' charges should be the same irrespective of their medical specialty is wholly unsupported by the testimony of Dr. Taylor cited by employer. Finally, as Dr. Loxley correctly maintains, Dr. Taylor's testimony that he could not dispute the documentation underlying employer's statistical analysis but that employer's figures seem extremely low does not support employer's conclusion that Dr. Taylor was in agreement with employer's method of statistical analysis.

SEC.7 (a) The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

(b) The employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under this Act as hereinafter provided.

* * *

The Secretary shall actively supervise the medical care rendered to injured employees, *** and may, on his own initiative or at the request of the employer, order a change of physicians or hospitals when in his judgment such change is desirable or necessary in the interest of the employee or where the charges exceed those prevailing within the community for the same or similar services

or exceed the provider's customary charges.

* * *

(g) All fees and other charges for medical examinations, treatment or service shall be limited to such charges as prevail in the community for such treatment, and shall be subject to regulation by the Secretary. The Secretary shall issue regulations limiting the nature and extent of medical expenses chargeable against the employer without authorization by the employer or the Secretary.

33 U.S.C. §907(a), (b), (b) (Supp. V 1987).

The pertinent regulation provides:

All fees charged by medical care providers for persons covered by this Act shall be limited to such charges for the same or similar care (including supplies) as prevails in the community in which the medical care provider is

located and shall not exceed the customary charges of the medical care provider for the same or similar services. Official state medical fee schedules for workers' compensation charges may be used as guidelines in determining the prevailing community rate where available and to the extent appropriate. The opinion of the OWCP district medical director that a charge by a medical care provider disputed under the provisions of §702.414 exceeds the charge which prevails in the community in which said medical care provider is located shall constitute sufficient evidence to warrant further proceedings pursuant to §702.414 and to permit the Director to direct the claimant to select another medical provider for care to the claimant.

20 C.F.R. §702.413.[9]

Proceedings concerning medical fees are initiated by the complaint of an interested party that a medical charge appears to exceed prevailing community charges for similar services, which is filed with the Director, Office of Workers' Compensation Programs (the Director), or upon the Director's own initiative. The Director is granted the authority to conduct an investigation and to make specific findings as to whether the disputed fee exceeds the prevailing community charges or the provider's customary charges. 20 C.F.R.

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[9] It is noted that 20 C.F.R. 702.413 provides that official state medical fee schedules for workers' compensation charges may be used as guidelines in determining the prevailing community rate. Section 702.413 additionally provides for the issuance of opinions of the OWCP district medical director whether charges exceed the prevailing charges in the community. The parties agreed at oral argument that Virginia law has no medical fee schedule and that no opinion was rendered by the OWCP district medical director.

§702.414. Section 702.415 of the Act's regulations provides that, following issuance of the Director's findings and proposed action, any interested party has the right to a hearing to be conducted in accordance with 5 U.S.C. §556 and with the procedures pertaining to adjudication of compensation claims found at 20 C.F.R. Part 702, Subpart C. See also 20 C.F.R. §§702.416, 702.417.

As a threshold matter, we hold that the administrative law judge erroneously placed the burden of proof on Dr. Loxley to establish that his fees do not exceed the prevailing community charges. While Section 7 of the Act does not directly address the question of the burden of proof in fee disputes, Section 702.415 of the regulations, 20 C.F.R. §702.415, provides for the right to a hearing pursuant to 5 U.S.C. §556. Thus, our disposition of the burden of proof issue under Section 7 and

the applicable regulations must be consistent with 5 U.S.C. §556(d), which provides, in pertinent part, that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." In the case at bar, employer is the proponent of an order ruling that Dr. Loxley's medical fees exceed the prevailing community charges, and, thus, employer bears the burden of proof with respect to this issue. See generally 5 U.S.C. §556(d); 33 U.S.C. §907(a), (b), (g) (Supp. V 1987); 20 C.F.R. §§702.407, 702.413-702.417.

We further hold that employer has failed to sustain its burden of proving that Dr. Loxley's fees exceed the prevailing community rate, inasmuch as employer's evidence is wholly insufficient to establish prevailing community charges for the medical services performed by Dr. Loxley. Employer's approach to defining prevailing community charges is vulnerable to attack on a number

of grounds. First, employer has provided no evidence that the medical fee data relied upon by employer represent a true sample of the medical fees charged by physicians practicing in the community since the charges used in employer's data base were compiled exclusively from medical bills submitted under employer's self-insured health benefit plan, a contractually negotiated plan between employer and the United Steel Workers, the employee's union bargaining agent. According to the agreement, employer would pay only those charges below the 80th percentile of all billings. Indeed, the administrative law judge recognized that the fees reflected in employer's sample would be distorted in employer's favor if physicians limited the charges submitted to employer's health benefit plan to the maximum 80th percentile level employer would pay.

It is interesting, as noted by the administrative law judge, that the purpose of setting a percentile by a health care provider, whether 75, 80, or 90, was to set the portion of a charge that the provider would pay, with liability to pay the balance on the patient. Decision and Order at 6, 17; Transcript of the Hearing at 111, 113, 128. This, of course, is a proper subject for negotiation between a health care provider and a union for the payment of charges under a health benefit plan. It is not applicable, however, under a workers' compensation system such as the Longshore Act which provides that the employer shall furnish all medical, surgical, and other related treatment. 33 U.S.C. §907 (a). Also, as noted by Dr. Loxley on appeal, employer's use of 1984 as a base year for 1985 billings fails to account for any intervening fee increases brought about by inflation or otherwise affecting the

prevailing community rates for 1985.[10] Further, no evidence was submitted as to the amount of charges rendered by physicians to patients in the general populations of the Norfolk-Newport News area covered under other plans, whether employer-provided plans or individually acquired plans. Thus, employer has failed to meet its burden of establishing that the fee data collected solely from its own health benefit plan represent an accurate depiction of the applicable prevailing community rates.

Second, employer's initial survey of fees charged to its health benefit plan fails to distinguish on the basis of medical specialization and, thus, is inherently flawed as a method of determining prevailing community charges. The Act and its

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[10] The increase in the cost of medical care in 1984 was 6.4 percent and in 1985 was 6.1 percent. Consumer Price Index (CPI-U) Medical Care, U.S. Department of Labor, Bureau of Labor Statistics.

regulations provide that medical fees shall be limited to prevailing community charges for "the same or similar" care. See 33 U.S.C. §907(b), (g) (Supp. V 1987); 20 C.F.R. §702.413, 702.414. Employer thus bears the burden of proving that fee data relied upon to establish the prevailing community rates are limited to charges for services which are, in fact, the same as or similar to those services rendered by Dr. Loxley. In the case at bar, employer merely compared Dr. Loxley's charges for the services codified by CPT Codes 90060, 90070 and 90220 with charges made by all physicians in the data base for services classified according to the same three broad CPT Codes, without presenting any evidence that services performed by these other physicians, in fact, constituted the same or similar care as that rendered by Dr. Loxley. We therefore hold that employer's failure to limit its fee data to only those physicians

practicing Dr. Loxley's specialty of orthopedic surgery renders its method of determining prevailing community charges insufficient to meet employer's burden under Section 7 of the Act. Employer's subsequent attempt to isolate fee data on orthopedic surgeons also is insufficient to sustain employer's burden, inasmuch as the sample of orthopedic surgeons' charges surveyed is quite limited, and, as in employer's initial survey, the data pertaining to orthopedic surgeons are limited to those doctors submitting charges to employer's health benefit plan. In light of our holdings that employer bears the burden of establishing that Dr. Loxley's fees exceed the prevailing community charges and that employer's evidence is insufficient to sustain its burden, the administrative law judge's determination that Dr. Loxley failed to demonstrate that his charges are within the prevailing community rates is reversed.

Accordingly, the Decision and Order of the administrative law judge is reversed.

SO ORDERED.

/s/ James F. Brown
JAMES F. BROWN
Administrative
Appeals Judge

/s/ Nancy S. Dolder
NANCY S. DOLDER
Administrative
Appeals Judge

/s/ Regina C.McGranery
REGINA C. McGRANERY
Administrative
Appeals Judge

Dated this 28th day of
February 1990

FILED: July 17, 1991

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 90-1449

NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY,

Petitioner,

versus

DR. SIDNEY S. LOXLEY; DR. LAWRENCE D. BOURGARD; DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,

Respondents.

O R D E R

Upon a request for a poll of the court on the petition for rehearing en banc, Judge Widener voted to rehear the case en banc, and Judges Ervin, Hall, Phillips, Murnaghan,

Sprouse, Wilkinson, Wilkins, and Niemeyer voted against rehearing the case en banc.

It is accordingly ADJUDGED and ORDERED that the petition for rehearing en banc shall be, and the same hereby is, denied.

The panel has considered the petition for rehearing and is of opinion it is without merit.

It is accordingly ADJUDGED and ORDERED that the petition for rehearing shall be, and the same hereby is, denied.

Judge Wilkins and Judge Michael concur in this order. Judge Widener dissents; he would grant rehearing for the reasons expressed in his dissenting opinion.

Judge Russell did not participate in the decision in this case.

/s/ H. E. Widener, Jr.

For the Court

Office of Administrative Law Judges
Suite 201
55 West Queens Way
Hampton, Virginia 23669
804-722-0571

	DATE ISSUED: May 27, 1987	
In the matter of	CASE NUMBERS	OWCP NOS.
DR. SIDNEY S. LOXLEY and DR. LAWRENCE D. BOURGARD Health Care Providers	86-LHC-1235	5-53675
	86-LHC-1232	5-54437
	86-LHC-1227	5-50747
	86-LHC-1233	5-52108
	86-LHC-1644	5-40872
	86-LHC-1760	5-46179
	86-LHC-1229	5-26614
v.	86-LHC-788	5-48617
	86-LHC-789	5-31472
NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY Employer	86-LHC-1234	5-52150
	86-LHC-1248	5-44571

John L. Smith, Esq.
For the Health Care Providers

Lawrence P. Postal, Esq.
For the Employer

BEFORE: John C. Bradley
Administrative Law Judge

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[1]The Claimants for whom services were rendered by Dr. Loxley and/or Dr. Bourgard are, respectively, (1) James C. Banicar, (2) Nathan Davis, (3) Ricardo Flanagan, (4) Eugene Howard, (5) Barbara Jordan, (6) Jesse Jordan, (7 Norman Lassiter, (8) Issac Minggia - 2 claims, (9) Pauline Sears, and (10) Vanessa Smith.

DECISION AND ORDER

This case arises pursuant to a request for hearing before the Office of Administrative Law Judges [OALJ] by the Newport News Shipbuilding and Dry Dock Company [NNS]. NNS challenges a determination by the Deputy Commissioner, Office of Workers' Compensation Programs [OWCP], Department of Labor, that the fees charged by Drs. Sidney S. Loxley and Lawrence D. Bourgard, orthopedic surgeons, did not exceed the prevailing community rate [PCR] for the services rendered. See 33 U.S.C. §907(b) and (g); 20 C.F.R. §702.413. Drs. Loxley and Bourgard had requested such a determination after NNS had refused to make payment in full for charges billed, but had, instead, limited payment to what NNS deemed to be the PCR.

Being released on this same date are decisions involving similar issues in Dr. Richard K. Neal v. Newport News Shipbuilding

and Dry Dock Company, 86-LHC-1225, et al, and Dr. Gilbert N. Snider v. Newport News Shipbuilding and Dry Dock Co., 86-LHC-1224, et al.

Our research is persuasive that these cases involve issues of first impression under §7(g) of the Longshoremen's and Harbor Workers' Compensation Act [LHWCA], 33 U.S.C. §901 et seq., and supplementing regulations, 20 C.F.R. §702.413-7.

I.

STATEMENT OF THE CASE[2]

While the parties failed to provide through adequate documentation or testimony a clear and detailed explanation of the actions which initiated this proceeding, it appears that in 1985 NNS declined to pay in full billings forwarded to it by Dr. Loxley and his associate, Dr. Bourgard, as a consequence of medical treatment for work-related injuries experienced by 10 NNS employees (EX 1, EX 2). Such treatment fell within the provisions of 33 U.S.C. §907 and, in the aggregate, involved 3 separate categories of charges, identified through the use of 5-digit CPT Codes.[3]

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[2]When making citation to the record, the following abbreviations will be used:

XHCP - Exhibit submitted by Dr. Loxley
EX - NNS Exhibit
TR - Hearing transcript

[3]The use of Current Procedural Terminology [CPT] Codes began in 1966 under the auspices of the American Medical Association [AMA], and was compiled with the assistance of physicians

While employees have the right to choose an attending physician, any resulting charges are "limited to such charges as prevail in the community," 33 U.S.C. §907(b), (g), and "shall not exceed the customary charges of the medical care provider for the same or similar services," 20 C.F.R. §702.413.

Under a health benefits plan negotiated with the Shipyard Union (Steelworkers) and covering approximately 77,000 shipyard workers and dependents, NNS agreed to pay physicians' charges in full for treating those insured under the plan, so long as the charge for a specified service did not exceed the sun within which there would fall 80% of all charges received the previous year (1984) for that same category of service (EX 2). Thus, the 80th percentile was used to establish the PCR, the highest

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representing all specialties of medicine (EX 3-2).

20% of the charges in a given category of service being treated as higher than the prevailing rate, and thus more than NNS is obligated to pay.

NNS then adopted the same standard for making payments for medical services in workman's compensation cases, including those here involved. In Dr. Loxley's situation the NNS policy resulted in the following: (EX 2)

CPT CODE	DOCTOR'S CHARGE	NNS PAYMENT	DIFFERENCE
90060	$ 38.50	$ 25.00	$ 13.50
90070	52.00	35.00	17.00
90220	122.00	110.00	12.00

Dr. Loxley successfully sought a ruling from the Deputy Commissioner, OWCP, that he was entitled to payment for charges as billed, and NNS then sought a hearing before an Administrative Law Judge. See 20 C.F.R. §702.415

II.

ISSUES

The record and representations of the parties considered, it appears that the focal issues to be resolved in this proceeding are, as follows:

(1) Which party has the burden of proving that Dr. Loxley's charges for services rendered are (or are not) in line with the PCR for the same or similar services/

(2) What geographic area should reasonably be deemed to comprise the aforesaid "community"?

(3) For a given CPT code service, in reaching a determination of the PCR is it appropriate to consider the rates of all physicians providing services which fall with the code's definition, or must separate consideration be given to each specialty?

(4) Did the party having the burden of proof, as referred to in item above, offer evidence sufficient to establish the PCR?

(5) Does an employee's "right to choose an attending physician", 33 U.S.C. §907(b), preclude use of the percentile approach invoked by NNS?

III

PROCEDURAL MATTERS

At the oral hearing, counsel for Dr. Loxley objected on grounds of relevancy to the admission of exhibits EX 8 (TR 47) and EX 13 (TR 49). EX 8 is a document consisting of 25 pages of varying length apparently compiled or gathered by Marlene J. Jones, Administrator, Virginia Beach Orthopaedic Associates [VBOA]. Exhibit EX 13 is a 43 page conglomeration of documents which appear to relate to various health care plans. Ruling on the objection was held in abeyance by reason of the voluminous nature of the documents, pending the opportunity to review them in detail and with some care.

Exhibit 8 relates to certain practices of VBOA. Conceivably, if some explanation of the significance of various portions of the text of EX 8 was literally dumped into the record without explanation of any kind. While the accompanying text attempts to be explanatory, it achieves something less than adequate success, often raising more questions than it answers. NNS, as the sponsor of EX 8, had the burden of establishing relevancy of the text contained therein. It failed to do so. Accordingly, EX 8 will not be admitted into the record.

EX 13 is an even more voluminous aggregation of documents. The observations directed above at EX 8 apply with greater force to EX 13. Accordingly, EX 13 will not be admitted.

IV

SUMMARY OF THE EVIDENCE

A. Stipulations

At the oral hearing the parties offered the following stipulations: (TR 4)

(1) Dr. Loxley provided the medical care for which he submitted the charges here in questions.

(2) The care was provided as a consequence of work-related injuries.

(3) The only issue to be decided relates to the extent to which the prevailing rate for such services may act as a limitation on the amounts due under the Act.

The stipulations were accepted at the hearing. However, after review of the record and contentions of the parties, it has been concluded that item (3) is ambiguous and falls significantly short of identifying the issues to be resolved in this proceeding.

B. The CPT (Current Procedural Terminology Code

Inaugurated in 1966 by the AMA and as most recently revised in 1986, the Current Procedural Terminology [CPT], "is a systematic listing and coding of procedures and services performed by physicians", each procedure or service being identified with a 5 digit code (EX 3-4). The purpose of the coding system is to provide, "a uniform language that will accurately designate medical, surgical and diagnostic services" (EX 3-2, 4).

The CPT codes here involved are as follows: (EX 3-17, 18)

CPT CODE	DESCRIPTION OF SERVICE
90060	Office Services, Established Patient, intermediate.
90070	Office Services, Established Patient, extended.
90220	Initial Hospital Care, Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records.

The CPT code seeks to distinguish among some services by further categorizing them as (a) minimal, (b) brief, (c) limited, (d) intermediate, (e) extended, and (f) comprehensive (EX 3-7, 8, 9).

Moreover, the system provides for the use of "modifiers." Number 22, for example, headed "Unusual Services", may be invoked when the service provided is greater than that usually required; and number 26 allows for a "professional component" (EX 3-5, 15).

While NNS neglected to provide information regarding CPT Codes confined to specific services of orthopedic surgeons, it is obvious that various specialties have their own series of 5 digit codes for some specialized services. To illustrate, under the identification, "Neurology and Neuromuscular Procedures" appear CPT Code numbers 95819 through 95999 (EX 3-19, 20, 21). Nevertheless, when a particular CPT COde service description is deemed

appropriate by the medical profession for use by more than one medical specialty, no attempt appears to have been made to distinguish between them.

C. Testimony of Dr. Sidney S. Loxley

Dr. Loxley and Dr. Lawrence Bourgard are participants in a group practice of orthopedic surgeons, all of whom are Board Certified (TR 82). At the time of hearing Dr. Loxley had been in his medical practice for 14 years (TR 83).

Loxley's group changes its rates almost every year, making adjustments "depending upon what we find out is the practice in the community" (TR 87). They have had to consider overhead increases "due primarily to liability insurance" (TR 88). A computerized billing system features use of the AMA-sponsored CPT codes (TR 84). Early in 1985 a conflict arose with NNS when it began to refuse paying in full the charge billed (TR 85). Loxley responded by

initiating a proceeding before the Deputy Commissioner, OWCP (TR 85).

Dr. Loxley has never received a complaint respecting his charges (TR 96), and does not think his charges for the 3 CPT codes here involved exceed the PCR (TR 91). The American Academy of Orthopedic Surgeons at one time published a Relative Value Scale which could be used to obtain information about what others in a community were charging (TR 86). When arthroscopic knee surgery came along, Loxley contacted orthopedic surgeons in the Norfolk area, Richmond and Charlottesville "to determine what would be a reasonable fee" (TR 88). He has been a board member of the Health Systems Agency (not further identified), Region 5, for 6 years, which allegedly puts him in contact with all kinds of pricing information (TR 89). More recently, a company in the Mid-West has begun publishing fee schedules covering the entire United

States, causing Loxley to believe his charges are 15% below the prevailing rates (TR 90).

Prior to hearing, Dr. Loxley attempted a local survey, but only a Dr. Morales and the VBOA responded (TR 101, 102). No fee discussions were had with orthopedic surgeons in Newport News or Hampton (TR 105), and Loxley could not provide date acquired from other orthopedic surgeons (TR 104).

While stating the he does not vary charges to patients, Dr. Loxley acknowledged there are certain exceptions (TR 91). His testimony on this point is somewhat confusing. Fees for service to Medicaid patients, who account for either 3% (TR 92), or 4% (TR 94), of Loxley's revenue, were said to be established in accordance with Congressional mandate (TR 92). Loxley has entered into agreements with HMO's (Health

Maintenance Organizations), among them United Medical Plan of Virginia [UMPVA], accounting for 3% of his business, Whittaker, less than 1%, and KeyCare, less than 1% (TR 96, 97). While HMO plans differ, it appears that Loxley is paid "modified fee" (TR 97), although UMPVA has a "set aside" fund from which additional payments possibly may be made, depending upon the degree of UMPVA's financial success (TR 98).

While about 30% of Dr. Loxley's patients are Blue Cross-Blue Shield [B/C-B/S] members, he does not participate as a B/C-B/S "provider" and does not accept what it pays as payment in full unless it actually pays in full (TR 94), apparently holding the patient responsible for any remainder. B/C-B/S, with 60,000 members in the area, collects data for the year prior to each April 1st, and then computes the "usual and customary fee" as has NNS, but at the 90th

percentile (TR 99, 104). B/C-B/S was described as the largest 3rd party payor in Virginia (TR 108).

There were said to be insurance companies which refuse to pay beyond a certain charge for services. Most such 3rd party carriers were said to be utilizing the 75th and 80th percentile, some the 90th, with the patient liable for the remainder (TR 110, 111, 113). The percentile utilized is based on data accumulated during the previous year (TR 112).

There are some 4,000 different CPT codes, and Loxley cannot recall either his own or the charges of others for services (TR 105). Concededly, he has no data to challenge use of the 80th percentile standard invoked by NNS (TR 106).

The Journal of the Medical Society of Virginia, published monthly, is a publication which receives general

circulation among physicians in the area (TR 133).

C. Testimony of Dr. Gervas S. Taylor, Orthopedic Surgeon

Board Certified in 1956, Dr. Taylor functioned as an orthopedic surgeon in the Norfolk area for 36 years (TR 21), and, at the time of hearing, was Chairman, medical Cost Peer Review Industrial Commission [MCPR] which was designed as a health cost containment program (TR 23). The MCPR was begun in 1980 to provide a mechanism for insurance carriers to question (a) unreasonable charges, and (b) the need for medical care in workmen's compensation cases (TR 23). A subcommittee of 5 doctors on which Taylor served in the Norfolk area, designated area 5, conducted hearings in about 50 of the 250 cases heard Statewide (TR 27). The doctors, for the most part, knew the prevailing rates in their particular specialties, "within reason" (TR

26). While Dr. Taylor acknowledged that the Federal Government "does not like lists", it is part of the MCPR program that when it has a case, the committee calls doctors and asks for information (TR. 38, 39).

Dr. Taylor could not recall the charges of any other doctor (TR 37), but believed he had "a very good idea of what the charges in the area are" (TR 38). Nevertheless, his committee has never reviewed an orthopedic surgeon charge in area in area 5 (TR 35), and Dr. Taylor was unable to say what were the charges of his own ground (of orthopedic surgeons in a group practice) in the 3 CPT categories here involved (TR 36, 55), stating only that his own fees differ from others in his group because he is acutely aware of health cost containment, while some others are not (TR 78).

Stating at one point that because "another group of people (the office managers) to work out the money situation" has been

interposed between doctor and patient, there is a great variation in charges (TR 56), Dr. Taylor, somewhat inconsistently, later testified that prices in the area tend not to vary much because of informal information exchanged over the telephone between office managers (TR 78). The prevailing rates are now generally managed by office managers (TR 55). The prevailing rates are now generally managed by office managers (TR 55). While Taylor has not recently called an orthopedic surgeon regarding fees, "office managers do a lot of that" (TR 39).

At first, Dr. Taylor seemed to be somewhat confused over Dr. Loxley's fees, apparently believing his charges for CPT codes 90060, 90070 and 90220 to be, respectively, $25.00, $38.50 and $122.00 (TR 32, 32). He then testified that the charges of $38.50, $52.00 and $122.00, respectively, were within prevailing charges within the community (TR 33), and were fair (TR 77). He represented

that charges for a return office visit range from $30.00 to $50.00, and an initial office visit from $85.00 to $125.00 (TR 33). While first testifying that he did not "have a problem with the eightieth percentile", believing, however, that NNS should notify doctors in the area about is policy (TR 57), and, further, that he did not think the peer group would have any problem with it (TR 58), Dr. Taylor later testified that NNS' 80th percentile figures for orthopedic surgeons were low, as are the average and most common charges (TR 77).

Dr. Taylor believes it to be a mistake to meld into the NNS statistical base data respecting both specialists' and generalists' fees (TR 67, 68), having earlier stated that an orthopedic surgeon will charge more for an office visit than a "primary care physician" (TR 34). The latter term was not explained.

Dr. Taylor offered the opinion that a specialist is one who is Board Certified in his specialist (TR 58), but added that the appellation should include those Board Eligible, i.e., those who have the necessary training and residency requirements but have not taken and passed the tests for certification (TR 59). It is admittedly difficult to determine who the Board Eligible specialists are (TR 58). The term could also include family practitioners who, incidentally, are now very sensitive about being Board Certified (TR 58). However, it would be extremely rare that a Board Eligible orthopedic surgeon would not have his name listed in the Yellow Pages (TR 70). There are "very few generalists in the old term left" (TR 58).

Taylor's patients came to Norfolk and Virginia Beach, from Newport News and Hampton, and, indeed, from all over the metropolitan area (TR 77). The differences

between the areas covered by NNS' program, his committee's area 5 and the Census Bureau's Metropolitan Statistical Area [MSA] are not significant in terms of prevailing charges (TR 54).

D. Paul C. Hartman, NNS Supervisor of Workmens' Compensation

In an effort to develop data concerning the PCR for various doctors' fees, NNS turned to 1984 computerized records obtained as a consequence of a health care plan negotiated with the Steelworkers' Union. Under the health care plan, a physician's charge was paid in full in 1985 so long as it did not exceed the level of charges within which 80% of all such charges fell in 1984 (TR 116; EX 2). The health care plan covers a total of approximately 77,000 employees and dependents and in 1984, resulted in payments to about 1700 physicians (EX 2). Under the health care

plan, an employee has a free choice of a physician (TR 131).

The data from the health care plan when applied to workmens' compensation cases (TR 128), and more specifically the 3 CPT code charges made the subject of Dr. Loxley's complaint, yielded the results set forth on Appendix A, attached hereto (EX 2, EX 7, EX 15; HCP 5).

Data developed for each CPT code does not differentiate between specialists; however, some CPT codes are appropriate only for a particular specialty (TR 118, 119). In an effort to obtain a list of doctors by specialty, NNS contacted Medical Societies in Virginia Beach, Norfolk and Hampton-Newport News (TR 120). The Norfolk society indicated that a list of Board Certified orthopedic surgeons was available, but that it would not include the Board Eligible (TR 120). Accordingly, to develop data confined to orthopedic surgeons, NNS relied on an

identification of those persons listed in the Yellow Pages as holding themselves to be orthopedic surgeons.[4]

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[4] In an effort to evaluate the validity of such an approach, we have compared the names witness Hartmann isolated via the Yellow Pages with those listed in the American Medical Directory published by the AMA, 30th Edition, 1986, as holding out orthopedic surgery as either a primary or secondary specialty in the Hampton Roads area, the results being as follows:

Political Jurisdiction	No. in Yellow Pages	No. in AMA Directory
Chesapeake	6	9
Hampton	5	7
Newport News	10	15
Norfolk	16	27
Portsmouth	9	12
Smithfield	0	0
Suffolk	0	3
Virginia Beach	11	18
Williamsburg	2	3
Yorktown	0	0
Total	59	94

The names of all listed in the Yellow Pages also appeared in the AMA Directory. It may be recalled that Dr. Taylor believed that names of orthopedic specialists would appear in the Yellow Pages.

E. The Relevant Geographical Area

The geographic area with respect to which NNS developed its data base related to places covered by mailing zip codes 23800 and may be identified as including the 7 principal Hampton Roads jurisdictions (Norfolk, Virginia Beach, Chesapeake, Newport News, Hampton, Portsmouth, and Suffolk), plus Yorktown and Smithfield (EX 16).[5]

The MSA conceived by the U.S. Census Board for Hampton Roads includes the 7 principal jurisdictions, plus York, James City and Gloucester Counties, and the cities of Poquoson and Williamsburg (EX 11).

The Eastern Virginia Health Systems Agency, a regional planning body for Eastern, Virginia, functions within a 5160 square mile area which includes 10 cities, among them Williamsburg, Franklin and

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[5]Great Bridge was included by NNS; however, its is merely a part of Chesapeake.

Poquoson, and 16 counties, among them the relatively distant Westmoreland and Accomack Counties (EX 4, EX 5).

E. Miscellaneous

B/C-B/S establishes a "prevailing rate" based upon data for the previous full year as of April 1 of a given year (EX 14). It does not distinguish between specialties. It does not in all cases pay doctor's charges up to the 90th percentile, the 85% applied in its KeyCare plan being an example. In 1985 the following standard applied:

CPT Code	Maximum Payment
CPT 90060	$ 36.00
CPT 90070	55.00
CPT 90020*	155.00

*Not CPT 90220

IV.

DISCUSSIONS AND CONCLUSIONS

A. In General

Our research has suggested that there is a paucity of decisions dealing with

physician's fees and the LHWCA. Indeed, aside from ALJ Lesser's decision in O'Donoghue v. McGrath Corporation, 5 BRBS 58 (1976), and ALJ Levin's decision in Dr. Ronald B. Greene v. Director, OWCP, 17 BRBS 166 (1984), there appears to be no decision by an ALJ, the Benefits Review Board, or a Federal Court specifically addressing doctors' fee issues under the LHWCA. Accordingly, when resolving certain of the issues herein it will be necessary to consider precedent involving portions of the LHWCA other than §7, or those arising under entirely different statutes.

The LHWCA provides, in part, that: (Emphasis Added)

"SEC. 7 (a) The employer shall furnish such medical, surgical, and other attendance or treatment * * * for such period as the nature of the injury or the process of recovery may require.

"(b) The employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under this Act as hereinafter provided * * * The Secretary shall actively supervise the medical care rendered to injured employee, * * * and may, on his own initiative or at the request of the employer, order a change of physicians * * * when in his judgment such change is desirable or necessary in the interest of the employee or where the charges exceed those prevailing within the community for the same similar services or exceed the provider's customary charges.

* * *

"(g) All fees * * * for medical examinations, treatment or service shall be limited to such charges as prevail in the community for such treatment, and shall be subject to regulation by the

Secretary. The Secretary shall issue regulations limiting the nature and extent of medical expenses chargeable against the employer without authorization by the employer or the Secretary".

Applicable regulations found at 20 C.F.R. §702.413 provide that: (Emphasis Added)

"All fees charged by medical care providers for persons covered by this Act shall be limited to such charges for the same or similar care as prevails in the community in which the medical care provider is located [and] shall not exceed the customary charges of the medical care provider for the same or similar services. Official state medical fee schedules for workers' compensation charges may be used as guidelines in determining the prevailing

community rate where available and to the extent appropriate."

§702.414 provides for investigation into the question of whether "any fee for medical treatment" meets the dual standard ("prevailing and "customary") specified in §702.413, and §702.415 of the regulations bestows on any interested party the right to seek an oral hearing before the OALJ, pursuant to 5 U.S.C. §556.

B. The Burden of Proof Falls On Dr. Loxley

Because meaningful evidence can be elusive in cases of this kind, the answer to the question of which party has the burden of proof may well determine which party ultimately prevails. The LHWCA does not address the burden of proof issue. However, Dr. Loxley urges (Loxley - 19, 20, 21; TR 15) that NNS has the burden of proof because (a) by refusing to pay fees, NNS became the proponent in seeking an OALJ order. Not surprisingly, NNS insists (a) that the issue

is whether Loxley proved his charges are within the PCR (NNS-2), (b) that because a claimant has the burden of proof, so dies Loxley (NNS-20, and (c) that Dr. Loxley's position is analogous to that of an attorney seeking approval of his fees under the LHWCA (NNS-22, 24; TR 12).

As a general rule of law the burden of proof in a controversy is upon the proponent, i.e., he who seeks to establish the affirmative of an issue, Selma, Rome & C. RAilroad v. United States, 139 U.S. 560, 567 (1891); Wilson v. Inter-Ocean Casualty Co., 188 S.E. 102, 105 (N.C. 1936); Reliance Life Insurance Co. v. Burgess, 112 F.2d 234, 238 (CA8 1940); Fleming v. Harrison, 162 F.2d 789, 792 (CA8 1947); and Hughes v. Litton Systems, Inc., 6 BRBS 301, 305 (1977). While the burden of proof stays with the proponent until termination of the action, the burden of going forward with the evidence may shift to the opposing party at

a given stage in the proceedings, Reliance Life supra, 112 F.2d at 238.

Again as a general rule of law, in cases wherein a physician has brought an action in court to recover fees for professional services rendered, the burden of proof has generally been held to be his to demonstrate that the fees in question are reasonable. See, for example Culverhouse v. Jackson, 194 S.E. 2d 585, 586 (Ga. Ct. App. 1972); Boulding V. Baum, 134 Ga. App. 484, 485 (1975); and Citron v. Fields, 30 Cal. App. 2d 51, 58 (1938).

In this proceeding, Dr. Loxley is in much the same position as a physician seeking a judgment in a State civil court. NNS declined to pay the full amount of the charges billed, and the doctor has sought an order requiring NNS to do so. He was, therefore, in the position of a proponent, a person seeking affirmation of his right to payment in full. In a civil court the

burden is on a physician to prove that his charges were reasonably, taking into consideration such factors, among others, as his usual fees, the physician's standing and reputation in the community, the skill required, the nature of the community, the value of services rendered and the patient's ability to pay, Citron v. Fields, supra., Gelpi v. Wilbert, 119 So. 455, 456 (La. Ct. App. 1928); and 70 C.J.S. §71.

Under the LHWCA and its supplementing regulations, the standard for determining whether a charge is reasonable is somewhat different than the plaintiff physician might encounter in a State civil court, but that should have no influence upon resolution of the burden of proof issue. Stated somewhat differently, if Dr. Loxley had elected to bring an action in a Virginia court of competent jurisdiction his would have been the burden of proving the charges to be reasonable. The fundamental rule of law

should be no different merely because he chose the forum provided in the Part 702 regulations.

We have considered whether or not Dr. Loxley was entitled to a presumption that his charges were not excessive, thereby shifting the burden of going forward with the evidence to NNS. However, neither the statute nor the supplementing regulations provide for such a presumption, and it is, accordingly, found not to exist.

We have also considered whether, as Dr. Loxley argues, NNS became a proponent and necessarily shouldered the burden of proof when it sought an overruling of the Deputy Commissioner's action. However, hearings before the OALJ require de novo consideration of the issues. To accept the Loxley argument would have the effect of according a presumption of correctness to the Deputy Commissioner's ruling -- an

approach antithetical to the concept of a de novo hearing at the OALJ level.

At the hearing and in the NNS brief [NNS-22] a question was raised as to whether decisions involving attorney's fees had any precedential value in resolving the burden of proof issue here. Section 28(a) of the LHWCA provides for the payment of a "reasonable attorney's fee" in an approved amount. The supplementing regulations appear in 20 C.F.R. §702.132, and require submission of a detailed application for approval--which, on its face, would seem to place the burden of proof on the one seeking approval of the fee.

There are other statutes which provide for the payment of reasonably attorney's fees to counsel for the prevailing plaintiff. In a civil rights case, Hensley v. Eckerhart, 461 U.S. 424, 437 (1983), it was held that, "* * * the fee applicant bears the burden of establishing entitlement to an award * * *."

In a class action case brought on behalf of Medicaid recipients, Blum v. Stevenson, 465 U.S. 886, 896, fn 11, the Court noted that the burden was on the fee applicant to produce satisfactory evidence "that the requested rates were in line with those prevailing in community for similar services * * *." What the Court did not find was that the burden of going forward with the evidence had shifted to defendant, thereby requiring him to establish that the fee sought was out of line with the PCR. See also Webb v. Board of Education of Dyer County, 105 S. Ct. 1923 (1985); and Daly v. Hill 790 F.2d 1071, 1079 (CA4 1986), both civil rights case.

In the absence of a clear intent evidenced in statute or regulation -- which is lacking here -- as a general proposition, there is no reason why the burden of proof should differ depending upon whether the person seeking payment of a fee for professional

services rendered is a physician or an attorney.

For the reasons stated, it is concluded that a physician seeking an order requiring payment of his charges in full for services rendered LHWCA claimant has the burden of proof, an evidentiary burden which remains with him through any appellate process.

C. The Applicable "Community"

Because the LHWCA gauges the reasonableness of a fee, in part, by comparison with those rates prevalent in the community, evidence was offered respecting the geographic boundaries applied by several entities to the Hampton Roads[6] community or upon a region centered on Hampton Roads. Two included Accomack County on Virginia's

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[6]An article appearing in the National Geographic magazine Vol 168, No. 2, July 1985, entitled "Hampton Roads, Where the Rivers End" identified (page 76) the 7 cities comprising Hampton Roads as being Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk and Virginia Beach.

eastern shore, and one included Richmond and Charlottesville, 90 and 160 miles, respectively, from Norfolk. By no reasonably measure can the "community" here involved be deemed to extend to such relatively distant places.

It would probably be acceptable to adopt the Census Bureau's MSA for this area as a reasonable definition of the "community" envisioned in the statute and accompanying regulations. The concept of the MSA is utilized in developing statistical information regarding demographics, industry and commerce and necessarily requires precise definition of boundaries. However, to require definition of the "community" here in terms of precise boundaries would serve no useful purpose. Rather, it would invoke burdensome technicality where none is needed.

It has been often noted by both the print and electronic media in Hampton Roads that NNS is the largest private employer in the Commonwealth of Virginia, employing, until recent reductions in force, approximately 30,000 people. The record is uncontroverted that its health benefits plan covers about 77,000 people. Recognizing, as Dr. Loxley testified, that patients may go outside their own political jurisdictions to those in the same general area when seeking medical treatment, nevertheless the area within which NNS's insured employees and dependents may seek medical treatment, is a sufficient definition of "community" for purposes of §7 of the LHWCA. Accordingly, it is concluded that the Hampton Roads community consists of the 7 cities names in footnote 6, plus nearby Smithfield and Yorktown.

It may be worth noting that, as shown by the aforesaid AMA American Medical Directory, physicians in the Hampton Roads community, and participating specialists, tend to locate in the more densely developed areas, Norfolk being the prime example. Consequently, the outlying jurisdictions tend to have few, if any, doctors listed.

Under these circumstances, outlying jurisdictions do not appear to be statistically significant, and it is doubtful whether the decision to include or exclude jurisdictions such as Smithfield or Yorktown would impact the results of the NNS survey.

We are aware from testimony in other cases that NNS sometimes sends workmen's compensation claimants to physicians outside the Hampton Roads area -- those at the Medical College of Virginia in Richmond being an example. However, it is understood

that the NNS survey was confined to the Hampton Roads area.

D. Separate Consideration By Specialty Unnecessary

Dr. Loxley has taken the position that the NNS 80th percentile approach is flawed because "NNS did not distinguish in its data among medical specialties" (Loxley - 5), alleging further that, "doctors who are specialists in orthopedic surgery charge more for services described by the same CPT Codes than do general care[7] physicians" (Loxley - 11). The basic proposition that specialists charge more seems to have been generally accepted by civil courts in assessing the merits of actions brought by physicians to recover fees for medical services.

[7]No effort was made to define what qualifies one as a general care physician, and no evidence on the point appears of record.

Under the facts of this case, Loxley's argument cannot withstand scrutiny. The fact is that when NNS enlarged its original survey data base to break out specifics relating to orthopedic surgeons, the following picture emerged:

CPT 90060		CPT 90070		CPT 90220	
*ORS	SURVEY	*ORS	SURVEY	*ORS	SURVEY
$30	$25	$30	$35	$100	$110
26.66	21.79	29.55	27.33	$79.66	89.87
$30	$20	$30	$20	$85	$100

(1) Rate at 80th percentile

(2) Average charge

(3) Most common charge

* Orthopedic surgeon special survey

As may be seen, considering the "bottom line" figure -- the rate at the 80th

percentile -- Dr. Loxley was paid more for services under 2 of 3 CPT codes using the general survey data then he would have been paid if NNS had confined itself to data respecting orthopedic surgeons.

There is a logical explanation for this development. At the 80th percentile level, the data developed in the original survey would necessarily include that relating to many specialists[8], including orthopedic surgeons. Indeed, Dr. Taylor testified that there are not many "generalists" left. On the record as made in this proceeding, a broad survey such as that conducted by NNS and including more than 46,700 charges submitted by approximately 1700 doctors[9]

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[8]The aforementioned American Medical Directory identified 84 separate "specialties", including GP (general practitioner) and FP (family practice).

[9]A count of the physicians listed in the aforementioned American Medical Directory revealed the following numbers:

Chesapeake	- 132	Portsmouth	- 210

need not distinguish between "generalists" and specialists in order to establish, with a reasonable degree of accuracy, the PCR.

Moreover, the medical profession itself established the CPT codes to provide "a uniform language that will accurately designate medical, surgical and diagnostic services." Under the circumstances, the NNS is justified in assuming that there are no significant differences in services given the same CPT code designation. If that assumption is somehow flawed, the remedy lies with the medical profession, Dr. Loxley included, to develop CPT codes more

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Hampton	- 148	Smithfield	- 5
Newport News	- 328	Suffolk	- 75
Norfolk	- 788	Va. Beach	- 593
*Poquoson	- 7	Yorktown	- 22
		Total	2,308

*Located contiguous to Hampton

Assuming the American Medical Directory to be reasonably accurate, the NNS survey appears to have developed fee data from more than 70% of the physicians in the Hampton Roads area. Note the heavy concentration of physicians in the more densely population jurisdictions.

accurately distinguishing between services rendered by physicians in different specialties.

Still further, if Dr. Loxley believes his services are more intensive, extensive or skilled than the more common run of his fellow physicians, there would appear to be open to him the use of "modifiers" to reflect that fact and serve as a basis for demanding higher fees.

E. Dr. Loxley Failed to Sustain His Burden Of Proof

When physicians have filed actions in State civil courts to recover fees for medical services, the more common practice has been to elicit opinions from persons engaged in the practice of medicine -- and thus deemed to qualify as expert witnesses -- concerning the reasonableness of the fees in question. See, for example, Womack v. Burka, 14 So. 2d 302, 304 (La. Ct. App. 1943); Spencer v. West, 126 So. 2d 423, 428

(La. Ct. App. 1960); and Loomis v. Traveler's Insurance Company, 169 So. 2d 544, 546 (La. Ct. App. 1964). Compare, ALJ Levin's decision in the Greene case, supra., 17 BRBS at 177, et seq.

The record in this case, however, does not establish that the two physicians submitting testimony on the issue -- Drs. Loxley and Taylor -- are knowledgeable concerning the PCR for each of the 3 CPT codes involved. Dr. Loxley's attempt at surveying other orthopedic surgeons in the area was not productive, and he could not provide data acquired from others. He provided no data to challenge the validity of the use by NNS of the 80th percentile standard, and, indeed, did not know the precise charges of his own group.

Dr. Loxley mentioned a publication which provided information regarding fees throughout the country. However, the best evidence concerning what is shown in any

such publication is the publication itself, not Dr. Loxley's version of what was shown therein. Consequently, no weight will be given to his testimony on the subject.

Dr. Taylor was even less persuasive. While he has been associated with the peer group review of contested medical fees, none involved a Hampton Roads area orthopedic surgeon -- which specialty Dr. Loxley insists is the only one for which relevant data can be applied. He was not aware of his own fee levels for the CPT codes in question, and seemed to rely vicariously on an informal office manager network for his opinions respecting PCR's.

It is probable that developments in anti-trust law have diminished a physician's ability to obtain meaningful pricing information. As Dr. Taylor observed, the government does not like lists. In Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982), the Supreme Court extended to

the medical profession the prohibition long standing in other areas of endeavor against the exchange of pricing information,[10] finding the practice of establishing maximum fee schedules and periodically increasing them to be a per se violation of the Shermans Act, 15 U.S.C. §1. Indeed, Dr. Loxley acknowledged that members of the medical profession are forbidden by law from independently collecting PCR data (Loxley-11).

It has been concluded that the testimony of Drs. Loxley and Taylor fell far short of establishing that Dr. Loxley's charges fall within the PCR.

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[10]Compare, American Column & Lumber Co. v. United States, 257 U.S. 377 (1921); United Stated v. American Linseed Oil Co., 262 U.S. 371 (1923); United States v. National Association R.E.B., 339 U.S. 485 (1950); National Society of Professional Engineers v. United States, 435 U.S. 679 (1978); and Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

F. The NNS Evidence Was Persuasive, Regardless Of Who Had The Burden Of Proof

Had it been concluded that the burden of proof rested with NNS, or that once the provision of medical services by Drs. Loxley an Bourgard had been established, the burden of going forward with the evidence shifted to NNS to demonstrate (a) that Dr. Loxley's charges exceeded the PCR, and/or (b) that his charges to NNS exceeded his customary charges for the same or similar services[11] the end result would have been the same.

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[11]NNS argues that NNS is entitled to, "the lowest rate the medical provider accepts as payment in full from others" (NNS-20). However, that is not quite what the statute provides. It and the regulations refer to "customary" charges. That a physician might accept a lower fee from an HMO (or from several) which accounts for a small percentage of his total business, or, indeed, may provide free medical service for indigents, does not establish that his customary charge is that accepted as payment in full from the HMO -- or nothing at all, which is what may be realized monetarily from treatment of a charity patient.

It would be naive to assume that no charge submitted by a physician to NNS was excessive, unreasonably or more than the PCR. The world is simply not that Utopian, and those who cannot resist the temptation to extract for themselves all the traffic will bear exist in every profession -- even the ministry, as recent revelations from South Carolina have demonstrated. Courts have, in individual cases, found physician's fees to be excessive. To illustrate, the Court in Citron v. Fields, 30 Cal. App. 2d at 58 reversed a trial court, referring to, "* * * the very large judgment given him which must shock the conscience until supported by more substantial evidence than now appears in the record." For similar observations, see Spencer v. West, 126 So. 2d at 429, and Loomis v. Travelers Insurance Company, 169 So. 2d at 546.

We view these judicial pronouncements as some support for the proposition that

charges submitted by some physicians are apt to exceed the PCR and are, therefore, unreasonable. That Congress recognized this proposition is obvious from its requirement that fees paid for treatment under §7 of the LHWCA must not exceed the PCR, or a physician's customary fee.

That there is a problem abroad in the land relating to the determination of reasonable fees for physicians is illustrated by an article appearing in the Washington Post issue of 1/9/87 headed, "Maryland Lists Fees of 4,200 Doctors -- Comparison Shopping Urged." There, the Maryland Attorney General's Office compiled data obtained from Federal Government programs and made public fee information relating to 4,225 of the States' 10,000 practicing physicians because, "We believe the price lists will promote competition among health care providers, which may help reduce health care costs."

To illustrate further, an editorial appearing in the New York Times on 1/13/87, mentioning that there are 557,000 doctors in the country and noting that, "billings have been jumping much faster than inflation," commented upon Congress' efforts to curb rising Medicare costs.

The problem of determining where the PCR line should be drawn is not an easy one, and does not lend itself to facile or precise determination. In the Greene case, supra, at page 175, ALJ Levin made the following statement:

> "For purposes of proceeding under Section 7(g) of the Act, I believe the term "prevailing community charge" may reasonably be defined as that charge or range of charges which a substantial number of physicians actually are paid for the same or substantially similar care or treatment in the relevant geographic market."

Having considered ALJ Levin's definition, but with the benefit of the factual findings in this case and the 2 others decided contemporaneously, it has been concluded that an apt definition of the PCR is, as follows:

> The least sum of money which a substantial majority of physicians in the relevant geographic market will customarily accept as payment in full for the same or substantially similar case or treatment.

That HMO's and insurance companies, as well as government-sponsored programs have moved toward the percentile approach is clearly established in the record. Those plans identified have selected percentile levels ranging from 75% to 90%. In some instances physicians agree to accept the percentile invoked as payment in full, even though their customary charge may exceed it. In others, physicians look to the patient

for payment of the remainder. Use of the percentile standard, however, appears to be a recognized and accepted practice in the community.

It would be an impossibility to determine at what precise lever the percentile standard must be established to reflect the PCR - 75% or 90%, 79% or 81%. However, a standard which accepts as being within the PCR 4 out of 5 charges received for the same or a similar service is deemed to be a reasonable one.

Turning to the initial NNS survey, the large number of doctors involved allow it to be characterized as far more detail and accurate than would data available from any other source. And, while Dr. Loxley argued (Loxley - 7, 17, 18) that the use of Yellow Pages to identify physicians who specialize in orthopedic surgery resulted in a very small data base, one too small to be statistically significant, the fact is that

a majority of the orthopedic surgeons in the community were included, that no better way of identifying orthopedic specialists would appear to be readily available, and that the resulting data confined to orthopedic surgeons is far more substantial and persuasive than the very imprecise and general opinions advanced by Drs. Loxley and Taylor.

The record supports the conclusion that the data developed by NNS succeeded in establishing a reasonable standard for determining PCR's, and fully satisfied the definition referred to on the previous page.

However, there is a potential problem which could, conceivably, arise in the future. NNS has surveyed 1984 charges to apply to 1985 billings. If, for example NNS is developing a 1985 data base utilized what is paid in 1985, rather than the charge billed, or if physicians billed no higher than the amounts they knew to be the maximum

NNS would pay, the result would be distortion in NNS' favor, increasing with each passing year. For the NNS approach to remain valid it will be necessary that all physicians bill their customary charges, regardless of what they anticipate the actual payment to be, that the NNS computer continue to calculate on the basis of charges, not payments, and that no significant number of physicians decline to do business with NNS employees because of the payment ceilings it imposes.

B. Claimant's §7(b) Rights Are Not Compromised

Dr. Loxley argues that the NNS standard violates a claimant's §7(b) right to choose his doctor (Loxley - 15). However, that right is by statute not without limitation. A claimant may seek treatment by a high fee physician, but the physician cannot charge more than the PCR or his customary charge. The physician is under no obligation to

accept a given claimant as a patient, and may not want to if he knows that he cannot expect to receive payment any higher than the PCR. To that extent, a claimant's right to choose his doctor has its limitation. But if the high costs physician accepts a claimant, he still is forbidden by law and regulation from charging in excess of the PCR. These limitations are real ones, and obviously have as their purpose protection against efforts by the acquisition to maximize income.

As something of a companion argument, Dr. Loxley (Loxley - 16) complains that the NNS plan was invoked without notice to the medical community, an argument which has a certain surface attraction. It would have been preferable if NNS had published notice of its planing a publication of general circulation within the Hampton Roads medical community, the Journal for the Medical Society of Virginia being an obvious

example. It would, perhaps, have been perceived to be more fair to Dr. Loxley if NNS had refrained from applying its plan to his billing until after he was given actual notice -- leaving him the option of accepting the plan or refusing to accept NNS employees as patients.

However, nothing in the statute or the regulations accommodates a ruling that the PCR standard cannot be applied until a physician has received notice, actual or constructive, of what an employer deems the PCR to be. Indeed, with or without notice, the statute provides that payments for treatment provided pursuant to §7 of the LHWCA cannot exceed the PCR. Consequently, notice is not an issue in this proceeding.

ULTIMATE CONCLUSIONS

The foregoing considered, it is concluded that:

(1) Drs. Loxley and Bourgard have failed to demonstrate that their charges for the

services of record herein were within the prevailing rates in the community for like or similar services.

(2) NNS demonstrated that the charges of Drs. Loxley and Bourgard for the services of record herein exceed the prevailing community rates for like or similar services.

(3) The 80th percentile approach invoked by NNS is a satisfactory standard for determining prevailing community rates, and the methodology applied by NNS to establish the 80th percentile was appropriate for that purpose.

JOHN C. BRADLEY
Administrative Law Judge

APPENDIX A

SUMMARY OF DATA BY NNS SURVEY OF CHARGES RECEIVED IN 1984

IN CONNECTION WITH HEALTH CARE PLAN

(See EX 2; EX 7; EX 15; HCP5)

Identification of Entry	CPT 90060	CPT 90070	CPT 90220
(1) Number of charges included in NNS survey	38,792	4,834	3,097
(2) Dr.Loxley's charge	38.50	52.00	122.00
(3) Maximum charge at 80th percentile	25.00	35.00	110.00
(4) Lowest charge found in survey	10.00	15.00	30.00
(5) Highest charge found in survey	40.00	100.00	200.00
(6) Average charge in NNS survey	21.79	27.33	89.87
(7) Most common charge in NNS survey	20.00	20.00	100.00
(8) No. of most common charges	10,434	1,610	881

WHEN DATA CONFINED TO
ORTHOPEDIC SURGEONS [ORS]

(1) No. of charges included in NNS survey	520	650	74
(2) Maximum charge at 80th percentile	20.00	30.00	100.00
(3) Average charge	26.66	29.55	79.66
(4) Most common charge	30.00	30.00	85.00
(5) No. of most common charges	215	573	26

Supreme Court, U.S.
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No. 91-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

DR. SIDNEY S. LOXLEY,

Petitioner,

v.

NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY, AND OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF IN OPPOSITION OF RESPONDENT NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY

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QUESTIONS PRESENTED FOR REVIEW

1. Whether there was substantial evidence in the record to support the Administrative Law Judge's finding of fact that Dr. Loxley's charges exceed the statutorily prescribed limit, in the Longshore Act, that a medical provider's charges not exceed the rates which "prevail in the community," 33 U.S.C. § 907(g)?

2. Whether the Administrative Law Judge correctly held that the proceeding before him was de novo, and thus Dr. Loxley, as the party seeking a compensation order, bore the burden of proof (since the Administrative Law Judge held that the Employer met the burden of proof, even if the Employer bore the burden of proof, this issue may be moot)?

LIST OF PARTIES

Pursuant to Rule 29.1 of the Rules of the Supreme Court of the United States, Respondent Newport News Shipbuilding and Dry Dock Company notes that it's parent corporation is Tenneco.

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BRIEF IN OPPOSITION OF RESPONDENT NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

The Respondent-Employer, the Newport News Shipbuilding and Dry Dock Company, by its counsel, respectfully submits this brief in opposition to the petition for writ of certiorari to the United States Court of Appeals For The Fourth Circuit (hereinafter referred to as "Dr. Loxley's Petition").

STATEMENT OF THE CASE

This case involves the application of section 7 of the Longshore and Harbor Workers' Compensation

Act, which limits the fees of medical providers to "such charges as prevail in the community for such treatment. . . ." 33 U.S.C. § 907(g). The reason for this limitation is that the employer has no control over the doctor an injured worker chooses, and yet the employer is liable for the doctor's fee.

Section 7 provides that the prevailing rate limitation "shall be subject to regulation by the Secretary [of Labor.]" *Id.* The Secretary of Labor issued regulations providing for a factual recommendation by the Deputy Commissioner, but then a *de novo* hearing before an Administrative Law Judge. 20 C.F.R. § 702.413-415. This is exactly how *all* Longshore Act factual disputes are resolved. The Deputy Commissioner holds an informal conference, without any discovery or any record being made, the Deputy Commissioner makes an *informal recommendation*, and then any party can demand a *de novo* hearing before an Administrative Law Judge. 20 C.F.R. § § 702.316-318, 702.332, 702.344 (referred to as Subpart C). The Judge's decision is then binding if there is substantial evidence to support it. 33 U.S.C. § 921.

Since there is no statutory or regulatory definition of the prevailing rate, the Administrative Law Judge must accept evidence on the issue, and make a factual determination. The Employer in this case used the statistical base of its self-insured health benefits plan for its evidentiary presentation. Being a large employer (largest private employer in Virginia), the Employer herein had an enormous statistical base—1700 local doctors. In terms of a cut-off for "prevailing," the Employer used the generous definition in its health insurance plan—80th percentile (as compared to the average or common charge which would be

much lower). Thus, if a doctor's charge was less than what 8 out of 10 doctors in the area charged for the same treatment, the charge was considered within the prevailing rate and was paid in full (Appendix at 60-61, 78-80).

SUMMARY OF THE ARGUMENT

The decision below merely dealt with the adequacy of the Employer's statistical evidence in establishing prevailing rates for medical charges. It is agreed by the parties and beyond dispute that the doctor's charges are statutorily limited to the prevailing rate. Thus, the decision below was inherently factual—establishing the prevailing rate in the community for similar medical care. Moreover, the decision was the first ruling by a Court of Appeals on this issue. As such, this case is not worthy of this Court's review.

The Court of Appeals put the burden of proof on the medical provider in cases in which the doctor alleges he was not paid pursuant to the prevailing rate. That ruling was merely a recognition that under the Secretary of Labor's regulations, the hearing before the Administrative Law Judge is *de novo*, and thus under the Administrative Procedure Act, 5 U.S.C. § 556, the party asking for an award, *i.e.*, money, bears the burden of proof. Moreover, the Administrative Law Judge found that even if the burden of proof was on the Employer, the Employer herein met the burden of proof. Thus, if the decision is upheld under the substantial evidence test, the burden of proof issue would never be reached.

The Court of Appeals itself recognized the limited importance of this case, voting 8-1 to deny Dr. Loxley's petition for rehearing in banc.

ARGUMENT

I. THE PREVAILING RATE LIMITATION OF THE LONGSHORE ACT FOR A MEDICAL PROVIDER'S CHARGE MERELY INVOLVES A FACTUAL ISSUE AND THUS IS NOT WORTHY OF THIS COURT'S REVIEW

Dr. Loxley, in his Petition, argues that the decision below mandates that an employer's health benefit plan limitations be applied under the Longshore Act. There was no such ruling by the Administrative Law Judge, Benefits Review Board, or the Court of Appeals. Rather, the Court of Appeals merely held that in the absence of a statutory or regulatory definition of prevailing rate, the question of determining the prevailing rate was an inherently factual issue. The Court of Appeals then merely accepted the Administrative Law Judge's findings of fact, which determined that the employer's evidence of prevailing rates was reasonable and was more credible than the doctor's evidence:

> Because the Act and regulations give no guidance on how to ascertain the prevailing rate, employers must devise their own means of doing so. Absent more definitive directions for determining the prevailing rate, we believe that an administrative law judge's conclusion that the employer met its burden of defining such a rate should be given great credence by the Board. *The evidence submitted at the hearing sufficiently supported the finding of the administrative law judge that NNS sustained its burden of proving the prevailing rates.*

Appendix at 16 (emphasis added).

The Court of Appeals did not hold that the employer's evidence from a health insurance plan is binding. Indeed, the Court of Appeals did not limit in any way the kind of evidence the doctor can submit to refute the employer's evidence:

> In making this conclusion as to the burden of proof, *we do not purport to determine how a physician should or could sustain this burden at an administrative hearing*. In the context of the record before us, however, we find that Loxley did not offer sufficient evidence to prove that his charges fell within the prevailing rate. As previously discussed, *Loxley offered little if any useful information as to what constitutes the prevailing rate. At the hearing, he did not offer any evidence attacking the methodology used by NNS*. Although Taylor testified that he thought the resulting prevailing rates were low, when asked whether he "had a particular problem" with the use of the 80th percentile, he responded, "I don't, personally, and I don't think the peer review group has any problem with that."

Appendix at 22 (emphasis added).

Neither the Administrative Law Judge, nor the Court of Appeals, set out a mandatory definition of prevailing rate. Rather, merely for convenience, the Employer used its statistical data from its health insurance plan. Similarly, in the absence of a definition of "prevailing," the Employer used the generous definition in its health insurance plan—80th percentile. The Administrative Law Judge merely accepted this

information as reasonable in the absence of any contrary convincing evidence from Dr. Loxley.

Dr. Loxley in his Petition raises three complaints as to the factual findings, but each were addressed and rejected by the Administrative Law Judge and the Court of Appeals. First, Dr. Loxley complains of the 80th percentile cutoff as being arbitrary. However, since it is greater than the most common charge or average charge, the Administrative Law Judge was free to use it as evidence of the prevailing rate (Appendix at 10 and 71-72, 110). As the Court of Appeals noted, even Dr. Loxley's own witness, Dr. Taylor, did not have a problem with the 80th percentile cutoff (Appendix at 6).

Dr. Loxley also complains of the use of the prior year's data, but the Administrative Law Judge and the Court of Appeals held that its use was necessary as a practical reality. (Appendix at 15n.8 and 111-112). Moreover, the use of the generous 80th percentile more than offsets the one year delay in the data.

Finally, Dr. Loxley requested differentiation by specialization. The Administrative Law Judge and Court of Appeals rejected this request because the American Medical Association ("AMA") coding, and the Longshore Act, do not so differentiate, there is no accepted list of specialists, and when the Employer tried to differentiate by use of the yellow pages' listing of orthopedists (the only available, and obviously crude, means of identification of specialization),there was no change in the outcome (Appendix at 10-14 and 97-101).

Dr. Loxley did offer the opinion of his fellow orthopedist, Dr. Taylor. Dr. Taylor, however, could pro-

vide no foundation for his opinion, conceding that he could not state any doctor's charges for the three medical care services at issue in this case, not even Dr. Taylor's own charges (Appendix at 5-6, 73-78, 103-104).

The mere recital of Dr. Loxley's complaints demonstrates that they involve factual issues. As such, Supreme Court review is not warranted. This is especially the case herein where no other Court of Appeals has addressed this issue.

II. THE BURDEN OF PROOF WAS PROPERLY PLACED ON DR. LOXLEY SINCE THE HEARING WAS DE NOVO AND IT WAS DR. LOXLEY WHO WAS SEEKING A COMPENSATION ORDER

The Court of Appeals accurately and properly addressed the burden of proof issue, relying on the fact the hearing before the Administrative Law Judge was *de novo*, and it was Dr. Loxley who was requesting a compensation order. The Court also noted that the regulations make the doctor, but not the employer, a necessary party, and presumably one of the necessary parties must carry the burden of proof. The Employer can add nothing to the Court of Appeal's analysis which relies on the Secretary of Labor's clear regulatory requirement of a *de novo* hearing:

> Neither Section 7 of the Act nor the regulations assign the burden of proof at the administrative hearing. However, for the following reasons we find that the burden is on the physician claiming that his charges are within the prevailing community rates. As the Board properly noted, under section 702.415 a party may request an administrative hearing pursuant to 5 U.S.C. § 556.

Therefore, subsection (d) of that provision, which states "Except as otherwise provided by statute, the proponent of a rule or order has the burden of proof," is applicable. This placing of the burden of proof is consistent with the traditional common law rule, noted by the administrative law judge, that the proponent - the one who seeks to establishes the affirmative of an issue—caries the burden of proof. *Selma, Rome & C. Railroad v. United States*, 139 U.S. 560, 567 (1891); *Fleming v. Harrison*, 162 F.2d 789, 792 (8th Cir. 1947).

Although the Board identified the proper rule regarding the burden of proof, it incorrectly applied the rule. Holding that NNS was "the proponent of an order ruling that Dr. Loxley's medical fees exceed the prevailing community charges," the Board assigned the burden to NNS. We find the administrative law judge's analysis more compelling. From a procedural perspective, the fact that NNS requested the hearing does not, *ipso facto*, make it the proponent of the issue. *The request for an administrative hearing by NNS was not, nor do the regulations provide for, an appeal from the finding of the Deputy Commissioner. Rather, the administrative hearing is a de novo proceeding which examines the same issue confronted by the Deputy Commissioner.* This fact compels us to make two observations: First, *it was Loxley, not NNS, who initiated proceedings to clarify whether his rate was within the prevailing rate.* Thus, the issue before the administra-

> tive law judge was raised by Loxley, not NNS. Second, as the administrative law judge noted, to hold that NNS carried the burden of proof at the hearing would effectively accord "a presumption of correctness to the Deputy Commissioner's ruling—an approach antithetical to the concept of a *de novo* hearing" before the administrative law judge.
>
> The regulations which govern the administrative hearing before the administrative law judge also support these conclusions. Section 702.416, a provision which the Board did not address in reaching its conclusion, states that "[a]t formal hearings held pursuant to § 702.415, the necessary parties shall be the person whose fee or cost charge is in question and the Director, or their representatives." The language of this regulation gives credence to our conclusion that one of the "necessary parties" must bear the burden of proof, and that language identifies a "necessary" party as a "the person whose fee or cost charge is in question." Whether the burden is assigned to "the Director" or to the "person whose fee or cost charge is in question" under the portion of the regulations, it is a reasonable conclusion that such burden is not assigned to one in the position of NNS.

Appendix at 18-21 (emphasis added).

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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DATED: March 17, 1992

Supreme Court, U.S.
APR 2 9 1992
OFFICE OF

No. 91-1415

In the Supreme Court of the United States

OCTOBER TERM, 1991

SIDNEY S. LOXLEY, PETITIONER

v.

NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the administrative law judge's determination that petitioner's charges for health care services exceeded the charges prevailing in the community for the same or similar services was supported by substantial evidence.

2. Whether the court of appeals properly allocated the burden of proof to petitioner on the issue of whether petitioner's charges for health care services exceeded those prevailing in the community for the same or similar services.

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BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-28) is reported at 934 F.2d 511. The decision and order of the Benefits Review Board (Pet. App. 29-53) is reported at 23 Ben. Rev. Bd. Serv. (MB) 215. The decision and order of the administrative law judge (Pet. App. 56-117) is reported at 20 Ben. Rev. Bd. Serv. (MB) 6.

JURISDICTION

The judgment of the court of appeals was entered on May 21, 1991. A petition for rehearing was denied on July 17, 1991 (Pet. App. 54-55). The peti-

tion for a writ of certiorari was filed on October 15, 1991. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In 1985, petitioner, a board certified orthopedic surgeon, provided medical care to ten employees of respondent Newport News Shipbuilding and Drydock Company (NNS) for work-related injuries (Pet. App. 59, 68).[1] NNS refused to pay the full amount petitioner billed for three categories of charges because it believed the charges exceeded the prevailing rate in the community, which is the amount allowable under the Longshore and Harbor Workers' Compensation Act (LHWCA). See 33 U.S.C. 907(g).[2] NNS computed the prevailing rate based on the procedure it used to determine benefits under its employee health care plan (Pet. App. 3-5).

NNS's health care plan covers 77,000 employees and their dependents (Pet. App. 4). Under its plan, NNS pays the full amount of an insured's medical expenses so long as those expenses "did not exceed the 80th percentile of charges for that particular service" during the prior year (*id.* at 4-5 & n.3; see *id.* at 60); charges in the highest 20% are considered to exceed the prevailing rate (*id.* at 60-61). The services rendered are identified by a uniform coding sys-

[1] Dr. Lawrence D. Bourgard, an orthopedic surgeon in petitioner's group practice, also charged for medical care rendered to the employees (Pet. App. 56 n.1). Although Dr. Bourgard was a party in the proceedings below, he is not a party before this Court (Pet. 5 n.1).

[2] The LHWCA limits fees payable for medical services "to such charges as prevail in the community for such treatment." 33 U.S.C. 907(g); see also 20 C.F.R. 702.413.

tem known as Current Procedural Terminology (CPT codes), which was adopted by the American Medical Association and is widely used by insurers and physicians, including petitioner, to designate medical, surgical, and diagnostic services (*id.* at 4 & n.2, 13, 68). In determining the 80th percentile for each CPT code in 1985, NNS relied on 1984 charges billed to its plan (*id.* at 78). For the three services at issue in this case, the data consisted of more than 46,700 charges submitted by approximately 1,700 physicians, representing more than 70% of the physicians in the applicable geographic area (*id.* at 15, 34 n.3, 99-100 n.9). CPT codes for the disputed charges, and therefore NNS's payment system, do not differentiate according to specialty of the physician providing the care (*id.* at 6, 13, 67-68). However, "the CPT code system allows for the use of modifiers," and "[b]y using a modifier, a physician can indicate that a particular service was altered in some respect even though its code number was not changed" (*id.* at 14 n.7).

For the charges disputed in this case, petitioner billed $38.50 (intermediate office visit for established patient, CPT code 90060); $52 (extended office visit for established patient, CPT code 90070); and $122 (initial hospital care, CPT code 90220) (Pet. App. 61, 66). In accordance with its plan, NNS paid petitioner at the 80th percentile for each service, resulting in payments to petitioner of $25, $35, and $110, respectively, for each service (*id.* at 5, 61).

2. Petitioner complained of the payment shortfall to the Director of the Office of Workers' Compensation Programs. See 20 C.F.R. 702.414. After an evidentiary hearing requested by NNS, an administrative law judge held that NNS's standard payments accurately represented the prevailing charges in the Hampton Roads, Virginia, community (Pet. App. 38

& n.7, 95), and that petitioner therefore was not entitled to payment of the disputed charges above those rates (*id.* at 114-115). In reaching that conclusion, the ALJ emphasized the extensiveness of NNS's survey data, which included a large number of charges submitted by a high percentage of area physicians (*id.* at 98-99, 110). Observing that other private and governmental medical insurers cut off payment at the 75th to 90th percentile, the ALJ deemed reasonable NNS's "standard which accepts as being within the [prevailing community rate] 4 out of 5 charges received for the same or a similar service" (*id.* at 82, 109-110).

The ALJ rejected petitioner's contention that NNS's methodology was flawed because it failed to distinguish among specialists, particularly orthopedic surgeons who, according to petitioner, charged more for their services than general care physicians (Pet. App. 97-98). Relying on data compiled by NNS for the administrative hearing, the ALJ noted that for two of the three disputed charges, NNS's payment to petitioner was greater than it would have been had payment been based solely on charges by orthopedic surgeons (*id.* at 98-99). The ALJ viewed this result as indicating that the charges of specialists were well represented in NNS's broad data base, enhancing the reliability of NNS's payment methodology (*id.* at 99-100). In addition, the ALJ concluded that the medical profession's use of CPT codes to designate services indicated that "no significant differences in services" existed in the "same CPT code designation" (*id.* at 100).[3]

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[3] The ALJ also noted that Blue Cross/Blue Shield likewise based its payments on charges submitted for the prior year and did not distinguish among specialties (Pet. App. 71-72,

In contrast to the persuasiveness of NNS's evidence, the ALJ found the testimony of petitioner and his one witness, Dr. Gervas S. Taylor, unconvincing as to the prevailing community charges for the three disputed codes (Pet. App. 104). Petitioner did not know the fees his own group or others charged for services,[4] nor did he present any basis for challenging NNS's use of the 80th percentile in setting payments (*id.* at 72, 102). Dr. Taylor, an orthopedic surgeon practicing in the community, served as chairman of a medical peer review committee that considered claims by insurers that medical charges were unreasonable (*id.* at 73). But like petitioner, Dr. Taylor was unfamiliar with the fees charged by his own orthopedic surgery group for the three disputed services (*id.* at 74, 103). Nor did the peer review committee during his tenure have occasion to review the fees of any local orthopedic surgeon (*ibid.*).[5]

Finally, noting that the LHWCA is silent on the issue (Pet. App. 86), the ALJ placed the burden of

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82). He further stated that if petitioner believed "his services are more intensive, extensive or skilled than the more common run of his fellow physicians," he could use the "modifiers" included in the CPT system to designate those services (*id.* at 101; see *id.* at 67).

[4] The ALJ recognized that physicians may be hampered by antitrust laws in gathering pricing information from their professional peers (Pet. App. 103-104).

[5] Dr. Taylor did not object to use of the 80th percentile to set payments, and thought his committee would approve that payment level (Pet. App. 76). Although Dr. Taylor thought that the charges of specialists should be segregated out of the data base, he opined that a "specialist" included physicians who were board eligible as well as board certified (*id.* at 76-77), and acknowledged that it was difficult to determine who was board eligible (*id.* at 77).

proof on the prevailing rate issue upon petitioner, as the party "seeking an order requiring payment of his charges in full for services rendered" under the Act (*id.* at 93). The ALJ stated, however, that "the end result would have been the same" regardless of which party bore the burden of proof (*id.* at 105).[6]

3. The Benefits Review Board reversed (Pet. App. 53). The Board held that NNS bore the burden of proving that petitioner's fees exceeded the prevailing community rates, and concluded that NNS's evidence was insufficient to sustain its burden (*id.* at 46-47). In the Board's view, NNS's payment methodology failed accurately to depict prevailing community rates because NNS computed payments based solely on charges submitted to its own health care plan, and did not consider charges billed to other insurance plans in the area (*id.* at 48, 50).[7] The Board also faulted NNS for using fee data from the previous year (*id.* at 49-50). In addition, the Board ruled that the 80th percentile cut-off for payment, while a proper subject of negotiation with the union, violated the employer's obligation under the LHWCA, 33 U.S.C. 907(a), to furnish all medical and surgical treatment to em-

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[6] The ALJ relied on the general principle that the party seeking to establish the affirmative of an issue bears the burden of proof (Pet. App. 87). As further support, he analogized petitioner's claim to that of a physician seeking to recover fees in a state civil court action (*id.* at 88-90), and to an attorney seeking fees under the LHWCA, 20 C.F.R. 702.132, or a civil rights statute (Pet. App. 91-92), all circumstances in which the proponent bears the burden of proof.

[7] The Board intimated that physicians might limit their charges to the amount known to be reimbursable under a particular plan (Pet. App. 48), thus skewing the data base, but the Board referred to no evidence supporting that theory.

ployees suffering a work-related injury (Pet. App. 49).

Finally, the Board decided that NNS's failure to distinguish by specialty rendered its methodology "inherently flawed" and contrary to the LHWCA's requirement that fees be limited to charges prevailing in the community for " 'the same or similar' care" (Pet. App. 50-52). See 33 U.S.C. 907(b) and (g); 20 C.F.R. 702.413, 702.414. And the Board dismissed NNS's specific survey of charges by orthopedic specialists because the sample was "quite limited" and, again, based exclusively on charges submitted to NNS's plan (Pet. App. 52).

4. The Fourth Circuit reversed the judgment of the Benefits Review Board and affirmed the ALJ's judgment (Pet. App. 2). Noting that the ALJ's factual findings are "conclusive upon the Board" (*id.* at 8), the court held that the Board had "erroneously expanded its scope of review by its independent analysis of the facts" (*id.* at 9). It further concluded, based on the record in this case, that petitioner "did not offer sufficient evidence to prove that his charges fell within the prevailing rate" (*id.* at 22).

The court agreed with the ALJ that NNS's data were representative of prevailing charges (Pet. App. 9-10). In the court's view, the breadth of NNS's data base also rendered inconsequential the fact that the data were derived from NNS's negotiated health plan and included no data from other health plans (*id.* at 10, 14-15). The court stated that to require a "more-encompassing survey of medical fees" would impose on employers a "cumbersome, indeed prohibitive, burden" (*id.* at 15).[8]

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[8] The court did not think that NNS's reliance on the previous year's charges undermined NNS's methodology. The court

Because the employer's obligation under the Act is limited to paying the charges prevailing in the community, the court rejected the Board's conclusion that using the 80th percentile standard violated the Act's requirement that the employer furnish all medical care for work-related injuries (Pet. App. 10). The court also rejected the Board's ruling that the NNS's approach violated the statutory prescription that the prevailing rate be for the "same or similar care" because NNS did not differentiate by specialty (*id.* at 11-12). See 33 U.S.C. 907(b) and (g); 20 C.F.R. 702.413, 702.414. Noting that the uniform CPT codes, by definition, designate "same or similar" services, and that both the Act and the regulations discuss comparable treatment without distinguishing between medical providers, the court concluded that the "use of the CPT codes is sufficient to define 'same or similar care' under the Act" (Pet. App. 13-14).[9]

In affirming the ALJ's conclusion that petitioner's "charges exceeded the prevailing rate regardless of who carried the burden of proof," the court recognized that it "need not decide on whom the burden falls in disposing of this appeal" (Pet. App. 17). Nonetheless, the court stated that the burden of proving prevailing community rates is upon the "physician who seeks an order compelling full payment of his charges" (*id.* at 17, 18). Although NNS had re-

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recognized that Blue Cross/Blue Shield also uses data from the prior year, and questioned whether the use of data from the prior month would produce a valid sample (Pet. App. 15 n.8).

[9] The court also referred to Dr. Taylor's testimony evidencing the difficulty in defining who is a specialist, and to the availability within the CPT codes of a modifier to indicate that special services were rendered (Pet. App. 14 n.7).

quested the administrative hearing, the court reasoned that petitioner was the party on whom the burden of proof properly fell because he had "initiated proceedings to clarify whether his rate was within the prevailing rate" (*id.* at 19-20). In addition, the regulation governing the resolution of fee disputes under the Act identifies the service provider and the Director, but not the employer, as "necessary parties" to a formal hearing (*id.* at 21). See 20 C.F.R. 702.416. The court concluded that the burden of proof should not fall upon a party who is not even required to participate in the proceedings (Pet. App. 21).

Judge Widener dissented, stating that NNS's use of data encompassing all physicians' fees rather than the fees of orthopedic surgeons violated the requirement of 33 U.S.C. 907(g) and 20 C.F.R. 702.413 that charges be limited to those prevailing in the community for the same or similar services (Pet. App. 26-27). He also noted that while physicians' charges under the LHWCA are subject to regulation by the Secretary of Labor, "it is not true that physicians' charges are subject to regulation by Newport News and the employees' union" (*id.* at 27). Finally, because NNS requested a hearing before an ALJ, Judge Widener deemed NNS to be the "proponent" of the issue and would have allocated to it the burden of proof (*id.* at 25-26).

ARGUMENT

1. Petitioner states that his "primary argument * * * is that the employer's fee schedule is illegal" (Pet. 22). He further contends that review is warranted because this case "is the only reported judicial decision construing the prevailing rate limitation on medical fees under the Act" (Pet. 11). To the contrary, the court of appeals' fact-based holding is unlikely to have a significant impact on medical providers. Therefore, further review is not warranted.

The court of appeals applied the proper standard of review in this case and correctly affirmed the ALJ's findings as supported by substantial evidence (Pet. App. 2). As the court recognized (*id.* at 22; see also *id.* at 98), the only issue before the ALJ was whether, based on the factual record in this proceeding, petitioner's charges were within prevailing community rates pursuant to 33 U.S.C. 907(g). The ALJ and court of appeals correctly rejected each of petitioner's contentions as to why NNS's methodology for determining prevailing rates was deficient—*i.e.*, petitioner's arguments that NNS erred by relying on the previous year's charges, by failing to differentiate by specialty, and by using the 80th percentile to represent prevailing charges. The use of the previous year's charges—which reflected the rates charged by more than 70% of the physicians in the area—yielded a large and reliable data base. Based on this information, NNS compensated petitioner at a rate acceptable to 80% of his fellow physicians in the same geographic area for the same kind of services. Moreover, the CPT codes by definition encompass "same or similar" services, and were the most readily available means to categorize medical services.

Thus, NNS's methodology for determining prevailing community rates, which is consistent with prac-

tices in the health insurance industry, is entirely reasonable. In the absence of specific guidance from the statute or the regulations as to how "prevailing" charges for "same or similar" services are to be determined, the court correctly upheld as supported by substantial evidence (Pet. App. 16) the ALJ's conclusion that NNS's concededly "extensive" evidence (Pet. 8) established prevailing community rates.

Furthermore, contrary to petitioner's assertion (Pet. 12), the court did not rule that "as a matter of law, this type of statistical data [derived from an employer's health plan] defines the prevailing rate for medical services under the Act," nor did the court "authorize[] any employer covered by the Act to implement its own mandatory fee schedule" (*ibid.*). Rather, this case presents a straightforward application of a statutory standard—charges prevailing in the community—to the particular facts of the case. Particularly in view of the "paucity of decisions" addressing medical fees under the LHWCA (Pet. App. 82-83; see Pet. 11), the ALJ's fact-intensive determinations do not merit further review.[10]

2. The court of appeals' discussion as to which party bears the burden of proof is dicta. This Court

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[10] Petitioner implies (Pet. 15-16) that a provider's fees are permissible if they merely comport with his customary fees. But the regulations provide that fees must be limited to prevailing community charges "*and* shall not exceed the customary charges of the medical care provider for the same or similar services." 20 C.F.R. 702.413 (emphasis added); see 33 U.S.C. 907(g). Although it appears that petitioner accepted lower fees for Medicaid patients and patients covered by agreements with several Health Maintenance Organizations (Pet. App. 70-71)—so that there was a question as to whether petitioner's charges to NNS represented his customary charges—the ALJ ruled only that petitioner's charges exceeded the prevailing community rates (*id.* at 37).

need not decide which party bears the burden of proof because allocation of the burden would not affect the outcome of this case.

The tribunals below agreed that "the proponent of a rule or order has the burden of proof," 5 U.S.C. 556(d), but differed on the application of that principle here (Pet. App. 19, 47, 87). Although the ALJ allocated the burden of proof to petitioner, he specifically stated that his ruling in favor of NNS would have been the same regardless of which party bore the burden of proof (*id.* at 105). Because the ALJ found (*id.* at 104) that "the testimony of [petitioner and his witness] fell far short of establishing" the charges that prevail in the community, while the evidence submitted by NNS was "persuasive" (*id.* at 105-112), the result in this case would have been the same even if the burden of proof rested with NNS (*id.* at 105).

Although the Board concluded that the burden of proof fell on NNS and that NNS's evidence failed to satisfy that burden (Pet. App. 46-47, 52), the Fourth Circuit affirmed the ALJ's conclusion that regardless of which party bore the burden of proof, petitioner's charges exceeded the prevailing community rates (*id.* at 16-17). The court recognized that it "need not decide on whom the burden falls in disposing of this appeal," but proceeded to state its view that petitioner bore that burden (*id.* at 17). Since the outcome of this case does not turn on the resolution of the burden of proof issue, and there is no conflict in the circuits on the issue, this Court need not consider the issue.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted.

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